The Impact of Hospital Downsizing on Registered Nurses Displaced from Full -Time Employment

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To my mom
who, by her example, taught me
about caring and learning and
the courage to do both well.

Abstract

This research identified and explored the various responses of ten women Registered Nurses displaced from full-time employment as staff nurses in general hospitals in southern Ontario. These nurses were among the hundreds in Ontario who were displaced between October 1991 and October 1995 as a result of organizational downsizing and other health care reform initiatives. The purpose of this research was to document the responses of nurses to job displacement, and how that experience impacted on a nurse's professional identity and her understanding of the nature and utilization of nursing labour.

This study incorporated techniques consistent with the principles of naturalistic inquiry and the narrative tradition. A purposive sample was drawn from the Health Sector Training and Adjustment Program database. Data collection and analysis was a three-step process wherein the data collection in each step was informed by the data analysis in the preceding step. The main technique used for qualitative data collection was semistructured, individual and group interviews.

Emerging from the data was a rich and textured story of how job displacement disrupted the meaningful connections nurses had with their work. In making meaning of this change, displaced nurses journeyed along a three-step path toward labour adjustment. Structural analysis was the interpretive lens used to view the historical, sociopolitical and ideological forces which constrained the choices reasonably available to displaced nurses while Kelly's personal construct theory was the lens used to view the process of making choices and reconstruing their professional identity.

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CHAPTER ONE: BACKGROUND

Introduction

Twenty-four hours a day nurses are the primary providers of the acute patient care services in hospitals. Of the estimated 14,000 public hospital workers displaced from their jobs since health reform initiatives began in 1991, many were nurses removed from their traditional caring role at the patient's bedside (Hospital Training and Adjustment Panel, 1993). Literature critical of health care reform examined the impact of organizational downsizing, rationalization of services and hospital mergers on the way health care was delivered, where and by whom. Some literature described the impact of health care reform on nurses and nursing labour. The whole story of health care reform in Ontario has not been told without the inclusion of nurses' narratives. There was, however, little information about the experience of job displacement from the perspective of women nurses who were displaced. By listening to nurses' stories of job displacement and understanding their relationship to the health care system, this study documented a previously neglected area of women's experience.

This research explored the stories told by ten Registered Nurses who were displaced from full-time employment because of hospital reform initiatives. Their stories represent the displacement event and their experience as they understood it. From their location as women and nurses in a hospital setting they described and made meaning of the event, surveyed their options and responded to job displacement. Through the process of hearing their stories, and writing about their anger and how they exercised power and control in the lives, their biographies become part of the history of this event and

demonstrate the tension between social structure and human agency. Retelling their stories also serves to question the gender arrangements that exist in bureaucracies and society, and highlights the political and economic forces that drive institutional restructuring.

This chapter describes the research problem and introduces the reader to the study. Specifically, chapter one includes: (1) a statement of the problem and the research questions; (2) the background of the problem; (3) the rationale for the study; (4) the significance of the study; (5) a definition of terms; and (6) the assumptions, limitations and scope of the study. This chapter concludes with a brief summary of the study and an outline of the remainder of the document.

Statement of the Problem and Research Questions

Organizational downsizing and other health care reform initiatives resulted in the job displacement of hundreds of nurses in Ontario hospitals between October 1991 and October 1995. This research identified and explored the responses of Registered Nurses displaced from full-time employment as staff nurses in general hospitals as a result of hospital reform initiatives. Specifically, this research addressed these questions:

1. What were the responses to displacement expressed by Registered Nurses who lost full-time employment in a staff position in a general hospital because of health care reform?
2. How did the experience of job displacement impact on the way Registered Nurses understood, made meaning of, or constructed their professional identity?

3. How did the experience of job displacement influence the way Registered Nurses understood changes in the nature and utilization of their nursing labour?

Background of the Problem

In 1991, reductions in transfer payments to hospitals resulted in the first round of cutbacks in programs and staff at the Ontario hospital where I worked as a nurse educator. Shocked and saddened, we watched fellow nurses leave the caring work they needed and wanted to do. A year later, further downsizing and more staffing cuts were necessary to "balance the budget." During the third round of cutbacks in 1993, administration labelled my role redundant and I, too, joined the ranks of the unemployed. Within a year of finding re-employment as an education consultant in another Ontario institution, hospital administration deleted that position citing cutbacks in services.

As reform initiatives continued to impact on hospitals, I found that opportunities to practice the educational dimension of nursing in a hospital setting became increasingly limited. Although I maintained my license to practice nursing, I decided to pursue graduate studies for the purpose of finding employment outside the hospital sector.

My story of job displacement was one of hundreds in the hospital sector. In 1992, the Hospital Training and Adjustment Panel (1993) estimated the Ontario government's overall health sector restructuring initiatives would affect as many as 14,000 public hospital workers. In a comparative analysis of 213 Ontario public hospitals, Cairns, Christiano, Dawson and Glassford (1994) found an overall decrease of 11,774.7 full-time positions or FTEs representing 11,354 employees. As hospitals were suffering the fastest decline when compared with all other health subsectors, and as further displacement of

hospital workers was anticipated, the authors concluded that the hospital sector "held little promise for future employment" (Cairns et al., 1994, Appendix A, p. 6).

No reliable figures were available on the number of Registered Nurses displaced from employment as a result of health reform initiatives. Data gathering across the health sector between 1991 and 1994 was incomplete and inconsistent (Cairns et al., 1994). A conservative estimate, however, drawn from the Health Sector Training and Adjustment Program (HSTAP) database suggested the extent to which Registered Nurses were affected by health care reform. In the brief period between February 1994 and September 1995, 961 RNs working in hospitals, community, and long-term care facilities were displaced (R. Mainolfi, personal communication, October 19, 1995).

The literature supported the prominent role of women and nurses in the Canadian health care system. Four out of five health care workers were women (Ross, 1991). According to Dalton (1990), one in every two health care workers was a nurse. This made nursing the single largest occupational group in the health care system (Armstrong & Armstrong, 1994a). A traditionally feminine occupation, women represented 97% of Canada's 250,000 Registered Nurses (O'Brien-Pallas, 1992). Three-quarters of working nurses were employed in hospitals, with 93% of those nurses providing direct care to patients (O'Brien-Pallas, 1992).

While these data indicated that women and nurses were a predominant segment of the Canadian health care system, there was a lack of complete and reliable statistical data to support the assumption that women more than men, and nurses more than other health care workers, were disproportionately affected by health care reform. What was clear, however, was that government initiatives that targeted the health care system and hospitals

impacted heavily on a work force comprised predominantly of women and nurses. Would this be reflected in the stories told by displaced nurses? How would they make meaning of their sizeable majority in the work force and their relative powerlessness to save their jobs or protect against the erosion of their labour?

The vast majority of my nursing colleagues and acquaintances sought re-employment inside the health sector, often with their previous employer. A handful searched for re-employment outside the health sector, and one or two engaged in entrepreneurial enterprises. Many identified strategies aimed at self-improvement, self-help, and retraining. While some increased their level of union activity, others severed ties with their union or professional group. One or two responded with legal action. From these informal observations, I formulated the first research question. What were the various responses to displacement expressed by Registered Nurses who lost full-time employment in a staff position in a general hospital because of health care reform?

In some ways, my position as a nurse educator in the health care system differed from the position held by my peers in nursing practice. Nurse educators tended to have a different educational and employment history, and a somewhat more privileged position in the hospital hierarchy. It was in considering these differences that I came to believe these factors defined the range of choices I had, and guided my responses to job displacement. Reflecting on my displacement experiences prompted the other research questions. If this was how I came to understand my displacement experience, how did other Registered Nurses make meaning of their job displacement experiences? How were nurses' responses guided by the social and organizational constructions of their professional identity? How did the experience of job displacement influence the way Registered Nurses understood

changes in the nature and utilization of their nursing labour?

Rationale for the Study

According to Yyelland (1995), "the predominant role of nursing within the organizations and distribution of health care services in Canada suggest that problems experienced by nurses within this system may have far reaching ramifications" (p. 1). Although hospital downsizing resulted in dramatic staffing cuts, little was written about the various ways displaced Registered Nurses responded to this event. This research filled a gap in women's studies and the health professional literature by exploring some of the responses of Registered Nurses to their job displacement. Documenting stories about displacement from caring work may be validating for nurses who shared this experience, and empowering for nurses, individually and collectively. Insights about how social and organizational constructs impacted on meaning making and professional identity may be useful to employer groups and other agencies planning retraining or labour adjustment programs for displaced nurses. Insights about how gender politics inform the economic and political discourse and practices of health care restructuring may be useful to professional associations and unions that act and react to the redistribution of nursing labour and wealth in health care institutions.

Significance of the Study

Displacement from full-time employment was a dramatic professional and economic change. Displaced RNs were deprived of familiar guideposts that defined their professional identity, like regular hours of work, salary, collegial association, and the use

of their knowledge, caring, and technical skills. This change required nurses to establish or recreate a professional identity, change their expectations about nursing and professional practice, and find new ways of working and coping.

Qualitative data collected in this study provided rich descriptions of the experience of job displacement from the perspective of ten Registered Nurses. The participants identified the sources of support available to them, and the social and organizational processes that impacted on their ability to respond to job displacement. How, when and which resources they mobilized to identify and meet their needs suggested how they retained or recreated their professional identity and asserted control.

As downsizing in the health sector and changes in the nature and utilization of women's labour are very topical issues, this work may be of theoretical value to others engaged in research in nursing, women's studies, sociology of labour and the sociology of health. Working from the data collected in this study, I discussed how nurses' responses were guided by the social and organizational constructs that impacted on their personal and professional identities. I also offered a possible explanation for understanding RNs' responses to the changes in the nature and utilization of their labour. For this reason, this research may also be of practical value to nurses and the nursing profession. As reform initiatives have affected many hundreds of Ontario nurses since 1991, I hoped nurses would benefit from hearing one another and that this might provide a catalyst for further dialogue and professional growth.

Definition of Terms

In general, terms used in this document reflect the definitions widely accepted in

the nursing profession and in the literature I have reviewed. In this section, I have indicated those instances where I universally restricted the use of given terms to a narrower or revised meaning.

Nursing was defined as "a preventive, educational, restorative, and supportive health-related service, provided in a caring manner, for the purpose of enhancing a person's quality of life or, when life can no longer be sustained, assisting a person to a peaceful, dignified death" (College of Nurses of Ontario, 1990, p. 8). Only an individual licensed by the College of Nurses has been able to call herself a nurse. Nursing was described as one discipline with two categories of nurses in Ontario: Registered Nurses, also known as RNs and Registered Practical Nurses, also known as RPNs, and formerly known as Registered Nursing Assistants or RNAs. In this paper, the terms Registered Nurse, RN, and nurse were used interchangeably and referred only to the category of Registered Nurses.

Because nurses have been predominantly female, and to maintain consistency and clarity of the written form, I used the female pronoun when referring to nurses. This was also consistent with the all female composition of the participant group.

A nurse has provided care to individuals or groups of individuals in a variety of settings such as hospitals, the community, and long-term care facilities. This research was limited to the study of Registered Nurses who worked in general hospitals where the client population was acutely or critically ill or convalescing. Four dimensions of nursing have been defined: research, management, education (my occupational focus) and nursing practice (the occupational focus of this study). While all dimensions have interacted, the central dimension and the one most familiar to the public, has been nursing practice.

A staff nurse was one whose occupational focus was nursing practice. Sometimes referred to as a bedside nurse, her primary function was direct patient care to individual clients and their significant others. A staff nurse may have provided direct patient care on a medical unit, in the intensive care unit (ICU) or the operating room (OR), for example. A nurse in a staff position was a "front line worker," usually reporting to a nurse manager, and occupying a base rung among professionals in the hospital hierarchy (Gregor, 1995). In this study, the terms nurse, bedside nurse, and staff nurse were used interchangeably to refer to a Registered Nurse in a staff position who provided direct patient care in any departmental setting in a hospital.

Cure or curative activities which emphasized diagnostic and treatment functions were generally considered to be the central function of physicians while care or carative activities referred to a more holistic approach to health care, and were central to the role of a nurse (Angus, 1995).

The Ontario Nurses' Association also known as ONA, is a union representing 50,000 registered or graduate nurses and certain other allied personnel working in hospitals, other health care agencies, and industry. While the nurses' union performs a variety of functions, the main focus is "to use the collective bargaining process to improve the social and economic welfare of its members" (Ontario Nurses' Association, n.d., p. 1). Many, but not all Ontario hospitals, have entered into contracts with the Ontario Nurses' Association. Many, but not all, Registered Nurses working in hospitals have been members of this union.

According to the Collective Bargaining Agreement between the Ontario Nurses' Association and Participating Hospitals (1993), a full-time nurse or one engaged in full-

time employment is one who is regularly scheduled to work an average of 35 hours per week. While hospitals who were not governed by this contract may have defined full-time employment differently, this was the definition assumed in this document.

The Collective Bargaining Agreement (1993, Article 10.07a) stipulated a layoff of nurses "shall be made on the basis of seniority provided that the nurses who are entitled to remain on the basis of seniority are qualified to perform the available work." Bumping was an option which allowed a more senior nurse whose position was affected by a layoff to take the position of another less senior nurse assuming the bumping nurse was qualified for the position into which she was bumping. If the hospital and the union came to an amended agreement about the method of implementing a layoff, that agreement took precedence over the contract (Article 10.08). Non-unionized hospitals were not bound by these rules.

Layoff, a term generally defined as a temporary loss of employment or an enforced period of unemployment did not reflect the differences in layoffs occurring in the hospital sector (Grayson, 1993). The use of the term in this document reflected the following differences: Hospital layoffs were characterized by varying degrees of unemployment and underemployment. Job displacement was the term more commonly used in this document to reflect the broader definition of the term layoff. Job displacement meant temporary or permanent discharge from a paid position as a result of organizational restructuring, job redesign, or downsizing, for example. The HSTAP also defined job displacement as a reduction in hours from an individual's preferred employment status (R. Mainolfi, personal communication, October 19, 1995). While job displacement included those who accepted early retirement and other buy-out packages, the term did not include those whose job

termination resulted from resignations or disciplinary dismissals.

If a nurse were unemployed, she was jobless. Some jobless nurses were actively engaged in a search for paid work while others were engaged in training programs for the purpose of finding re-employment. If a nurse were underemployed, she experienced a discontinuity of working hours characterized by a reduced level of employment as compared with her preferred or pre-displacement employment status.

While some nurses were displaced permanently, many were placed on employee recall lists. The Collective Bargaining Agreement (1993, 10.7a) stated, "Nurses shall be recalled in the order of seniority, unless otherwise agreed between the Hospital and the local Association, provided that the nurse is qualified to perform the available work." Of those on recall lists, some were never recalled to work by their former employer; some were recalled to part-time or casual work; and still others were recalled intermittently over extended periods of time (Grayson, 1993).

Labour adjustment referred to the degree to which a displaced nurse maintained or re-attained her previous economic, psychological, and physical well-being (Grayson, 1993). Economic adjustment was measured by current employment status, degree of continuity of working hours, and ability to maintain pre-layoff wages and skill utilization.

The health sector referred to those government bureaucracies involved in the prevention and treatment of illness and disease, and the maintenance of health and well-being. The health sector is composed of many subsectors. The hospital sector is the largest subsector and includes acute care, psychiatric, and extended care hospitals (Ontario Ministry of Health [OMOH], 1993). This study was limited to nurses employed in the hospital sector, specifically acute care or general hospitals.

The Ontario Ministry of Health (1992) defined health care reform as an overall restructuring initiative intended to control costs while preserving medicare, promoting health and public health policy, and improving the quality of health care services. Citing hospitals' costs as 44% of the total 1993/4 health budget, hospital reform was identified as a strategic priority for restructuring (OMOH, 1993). Monies realized from hospital restructuring were to be reallocated to the community-based health care services.

In the hospital sector, restructuring takes the form of restrictive admittance policies, standardized length of stay, early patient discharge, bed closures, increased outpatient services, and program and staff cuts (Ontario Council of Hospital Unions/Canadian Union of Public Employees [OCHU/CUPE], 1995). Organizational downsizing is a restructuring strategy for meeting budgetary requirements. Downsizing is achieved with: (1) changes in hierarchical structures like flattening organizations and self-managed work teams; (2) headcount reduction through layoffs, attrition, job sharing, and early retirement; and (3) changes in the nature and utilization of labour like job relocation, reduced work week, job re-engineering, and job consolidation.

A distinction was made in the way the terms public and private were used and understood. Private sector denoted that which is done privately in the for-profit economic sector while public sector referred to government initiatives or that which is done by the state. Private also referred to that which is done in the domestic sphere as opposed to that which is done in the market place or the public sphere. In clarifying these terms, Armstrong (1995b) stated "these distinctions are easier to make in theory than in practice" (p. 2). Glazer (1993) argued the dichotomy was an expression of the gendered and separated nature of men's and women's worlds.

Assumptions, Limitations and Scope of the Study

This study, like all naturalistic inquiry, assumed that there are "multiple constructed realities that can be studied only holistically" (Lincoln & Guba, 1985, p. 37). Thus the experience and responses of Registered Nurses to job displacement could only be understood in the context of the social, economic and political forces existing in hospitals and the health care system. The purpose of this study was to identify and describe the responses of Registered Nurses from the perspective of those who lived this experience and, in so doing, achieve some level of understanding about the experience of job displacement. "Concepts about how the world actually works are located in one's experience of the world" (Gaskell, 1992, p. 137). How these women contextualized and made meaning of their experience was critical to understanding their responses.

This study presents a textured picture of job displacement from the perspective of ten displaced nurses. Kelly (1963) told us that constructs are "ways of construing the world" (p. 9). These constructs are subject to revision. As we are shaped by events, so do we play a role in shaping events. Recent events in a person's life, like job displacement, may influence the ways in which people construe the world. This study questioned how the experience of job displacement affected the constructs of the ten women studied.

As I began this study I questioned how women and nurses who constituted a huge majority in the hospital hierarchy and health care system could be so powerless and ineffective in protecting their jobs, the scope of their labour and the integrity of their profession. Nurses did not seem to launch any political response to job displacement or drastic cuts in staffing, nor did I hear them fighting for their own job or for their profession. I questioned whether or not nurses, most of whom were women, were

targeted for displacement largely because government and administrators anticipated this non-response.

As angry as I was that nurses seemed to collude in their own victimization, I knew my own act of "leaving quietly" was no different than the response I criticized. This research, like other critical research, arose from a personal desire to identify and explain those elements which created or magnified organizational inequities in power. In this case I was interested in exploring those factors that inhibited the growth of nurses' potential in hospitals and health care.

Some of the literature I examined for this study suggested that current health care reform has been driven by false assumptions about overspending and saving medicare. Language about promoting health and increasing accessibility to health services through partnerships and better use of resources has been used to win public support for right wing business agendas. Those with political power have driven this change but have been largely protected from its consequences. Those without political power, such as nurses, have suffered the consequences and have been relatively silent. I set out to break that silence, to listen to what nurses had to say about their displacement.

The data I collected changed my initial view. The nurses I studied did not see themselves as totally powerless any more than I had. Rather, they saw themselves as workers constrained by a bureaucracy that limited their political action. They did not willingly accept their displacement but were angrily fighting back in all the ways available to them. By engaging in this research and writing about the experiences of displaced nurses, I am not trying to speak for them but, rather, as Klein said, I am "speaking *out* for them" (Klein as cited in Reinharz, 1992, p. 16).

Klein's words embodied one of the central tenets of the narrative tradition. Using narratives in research has been a way to unearth those details and complexities of human social action that were not revealed when using other research methods. Many writers such as Klein, Heilbrun, Drake, Connelly and Clandenin have employed this established tradition to explore human experience from a different perspective. Narratives have been ways of understanding the world and making meaning.

> Personal philosophy is a way that one thinks about oneself. It goes beyond expressed values and beliefs and refers to a reconstruction of meaning of one's actions in context of one's narrative. That is the beliefs and values are grounded and contextualized in terms of the events of one's life. (Connelly & Clandinin as cited in Drake, 1992, p. 174)

The language women used, their experiences and their temporal and social location shaped the stories they could tell. Women have been socially constrained to use the language and restrict content so that what they had to say was not trivialized or diminished as female, political or offensive (Heilbrun, 1988). An American political theorist described writing her autobiography "experimenting with different ways of writing and trying out alternative voices" (Elshtain as cited in Reinharz, 1992, p. 16). A feminist author and researcher reported that the 64 women she interviewed "needed to tell stories to communicate meaning" (Yeandle as cited in Reinharz, 1992, p. 24).

The women in this study used story telling as their vehicle for meaning making. As Heilbrun (1988) said that narratives have been the way wherein "the woman may write her own life in advance of living it, unconsciously and without recognizing or naming the process" (p. 11). In the process of telling her story, each participant tried to make

meaning of her displacement by choosing her own words and reshaping her own experiences to understand her own story from her location as a displaced nurse and a woman in the world. That narrative was her story and became her history (Heilbrun, 1988). The individual narratives of these participants, together with my understanding and interpretation of their collective stories, formed the basis for this research.

Summary and Outline of the Remainder of the Document

Health care reform initiatives resulted in the job displacement of hundreds of Registered Nurses in Ontario. This study identified and explored the responses of staff nurses to displacement from full-time employment in general hospitals. Qualitative data collected in this study provided rich descriptions of the experience of job displacement from the perspective of the displaced Registered Nurse. How the experience of job displacement impacted on the way Registered Nurses understood, made meaning of, or constructed their professional identity, and understood changes in the nature and utilization of their nursing labour were also explored.

The details of this study are reported in the next four chapters. Chapter two begins with a review of literature critical of the assumptions, process and outcomes of health care reform. Literature examining how nurses and nursing labour have been impacted by reform initiatives is also presented, as well as an examination of the historical, structural and ideological constraints that have shaped nursing and nursing labour. Chapter two concludes with a discussion of human agency and structural analysis, two theoretical frameworks used to interpret social phenomena. The process of defining the research methodology is discussed in chapter three. All other aspects of the research

methodology are also presented in the third chapter including the research design and procedures, the selection of participants, data collection and analysis. The fourth chapter presents the research findings, and several themes are identified and discussed under the broader headings of the three research questions. Chapter five is devoted to a discussion of these findings as they are made understandable in the context of the literature. Conclusions from the analysis are presented followed by implications for the education, retraining and labour adjustment of nurses, as well as recommendations for future research.

CHAPTER TWO: REVIEW OF THE LITERATURE

Introduction and Overview of the Chapter

Fundamental restructuring of health care in Ontario and across Canada during the early 1990s affected the way health care was delivered, where, and by whom. Hospital downsizing and job displacement emerged as two highly visible reform initiatives. This chapter introduces literature which offers both macro and micro analyses of health care reform and its outcomes related to nursing and nursing labour. I begin with literature which critically examines assumptions driving health care reform, incongruities between the proposed and the actual process of reform, the partnerships formed by the Ontario Ministry of Health, and the shift toward privatizing care. This is followed by an examination of the historical, sociopolitical and ideological forces that have shaped nursing and nursing labour in Canada. Another area of literature examines how nurses and nursing labour have been impacted by health care reform. Finally, human agency and structural analysis are presented as ways of understanding social action. In this study these perspectives were used to analyze the narratives of Registered Nurses. This literature review suggests that current health care restructuring initiatives are best understood in light of recent economic shifts, the changing role of the state and the impact of these changes on institutional practices.

Health Care Reform

Recent health care reform in Canada and Ontario has sparked considerable debate in the legislature, the media and the academic world. In the mid 1980s the Ontario

Ministry of Health commissioned three major enquiries into health and health care. As a result, the Premier's Council on Health Strategy (1991) was established in 1987 to identify strategic priorities and build consensus for change. In the early 1990s, the ministry claimed that sweeping institutional reordering was necessary to respond to profound structural and global changes in the economy. The Ontario Ministry of Health (1992) proposed goals and strategies for fundamental restructuring of health care intended to control costs while preserving medicare, promoting health and public health policy, and improving the quality of services.

Four fundamental, political and economic forces have impacted on the institutional discourse and practices of the health care sector. These are: (1) a general emphasis on advancing technology (Duffy & Pupo, 1992; Scott, 1995) and, specifically, new medical technologies (Armstrong & Armstrong, 1994a; Duffy & Pupo, 1992; Glazer, 1993; Scott, 1995); (2) changes in the nature and distribution of work (Armstrong, 1995b; Glazer, 1993; Wilson, 1991); (3) the free trade agreement, closer economic ties to the United States and the unity debate (Armstrong & Armstrong, 1994a; Badgley & Wolfe, 1992); and (4) evolving demographic shifts (Badgley & Wolfe, 1992; Wilson, 1991). It is within this national context that Ontario health care reform is located.

In the body of literature critical of health care reform, the contributions of a Canadian scholar, Pat Armstrong, and an American researcher, Nona Glazer, have been significant. Because their discussions have been clear, provocative and helpful in exploring this issue, their works have been cited widely in the literature and in this review.

Four themes have emerged from the literature: (1) challenges to the assumptions driving change; (2) the incongruities between the proposed process of change and the

actual implementation of change; (3) the partnerships formed by the Ministry of Health; and (4) the shift toward privatization of health care. Looking at each theme in turn, this review begins by examining the assumptions on which reform was predicated.

One assumption driving health care reform in Ontario and across the country was that Canadians were overspending on health care. The Ministry of Health cited escalating expenditures over the last 10 years to show that Ontario was overspending on health care. They claimed health care costs had risen annually over the last decade by an average of 11.3% (OMOH, 1992). The Annual Report 1992-3 (OMOH, 1994a) showed 32% of the total provincial budget or $17 billion was allocated to health care. The Ministry of Health used these figures to support the need for health care reform. A government funded report, When Less is Better: Using Canada's Hospitals Efficiently (Working Group on Health Services Utilization, 1994) was based on the presumption that health care costs could not be sustained at the previous rate of growth if the system were to continue to operate.

Some researchers, however, have revealed that, when compared to other countries, Canada was not overspending on health care. During the same time frame, Canadian health care costs were comparable to other countries with national health care schemes like Germany, France, Australia and the Netherlands (Armstrong & Armstrong, 1994b). Evans' research on the international movement to restructure health care systems indicated that Canada's health care costs "have in fact escalated much *less* [italics in original] rapidly during the 1980s than in any of the three previous decades" (as cited in Armstrong & Armstrong, 1994b, p. 20). While Lexchin (1994) agreed that health care costs were rising, he claimed they were not growing any faster than during the last four

decades. Between 1991 and 1993, expenditures in the Canadian public system grew much more slowly than in the largely private American system (Armstrong, 1995b). Similar assumptions about escalating costs were used in the United States to justify reform. Cuts to funding for health care reflected a popular mandate in Glazer's study (1993) of American hospital administrators, managers, educators and nurses. That health care costs have reached a crisis point had been "accepted unreflectively" (p. 117) by many social scientists in North America. Wotherspoon (1994) reported that hospital expenses constituted a majority of overall health care expenditures and noted without comment that physicians' salaries and other related expenses were not included in the calculation.

As the Canadian economy suffered considerable decline, health care costs consumed more of the gross national product. Armstrong and Armstrong (1994b) argued that the complex funding arrangements, not overspending, were undermining health care. Funding arrangements dating back to 1977 have shaped the structure of the Canadian health care system dictating how and where services were provided and by whom. One feature of these funding arrangements was the way costs were shared by federal and provincial governments and insurance companies.

Although health care costs were paid primarily by tax revenues, Ontario received transfer payments from the federal government. Federal transfer payments accounted for 50% of provincial health care funding in 1980. By 1994 these transfer payments were reduced to 30% driven by what has been called an "obsession with the deficit at all levels of government" (Lexchin, 1994, p. 10). As federal transfer payments to Ontario shrank, so too did the provincial budget base for health care expenses. Reductions in transfer payments, not overspending, accounted for the disparity between revenue and

expenditures, and the apparent crisis in health care funding.

Hospitals were considered prime offenders for overspending and inefficiency. The Ontario Ministry of Health (1992) claimed hospital operating costs had increased by two and a half fold in the last decade with hospital services in 1992-3 accounting for 13.8% of all government expenditures. A government-appointed task force, The Working Group on Health Services Utilization (1994) reported that hospitals were consuming approximately 40% of all health care resources or $30 billion annually. Citing these figures, the Ministry of Health made hospital reform a strategic priority.

Again, Armstrong and Armstrong (1994b) charged that legislated funding arrangements reinforced a highly decentralized hospital-based system dominated by physicians. The 1984 Health Care Act, which was intended to reduce extra billing by physicians, redefined hospital services as a service "medically necessary for the purpose of maintaining health, preventing disease or diagnosing or treating an injury, illness or disability" (as cited in Armstrong & Armstrong, 1994b, p. 21). This definition largely restricted health care services to acute care delivery at in-patient and out-patient clinics in hospitals where physicians served as the primary gatekeepers.

Another assumption underlying recent health care reform was that cost cutting was necessary to preserve medicare. Although the Ontario Ministry of Health (1992) acknowledged that the 1992 economy saw the worst recession since the 1930s, they claimed health care reform was not a reaction to the recession. Armstrong and Armstrong (1994a) argued that the federal Conservatives used the fear generated by the recession to convince Canadians that the national debt and the fragile economy were the result of the greed, inefficiency, and dependency of individual Canadians. Drawing an analogy between

the national debt and overspending on a personal credit card, the Mulroney government asked Canadians to accept drastic cuts in public spending as the personal sacrifice and effort needed to recover a healthy economy. The government also used Canadians' desire to preserve medicare to justify "a transfer of responsibility from the 'slipshod' public sector to the 'efficient' private sphere" (Armstrong & Armstrong, 1994a, p. 31). Purportedly, the private sector, driven by business principles, would be lean and more responsible with health care dollars than the public sector which had proven itself to be fat and inefficient. This shift to the techniques and technologies of the private sector was a form of privatizing health care and is discussed later in this section.

In addition to cost-cutting measures, the Ontario Ministry of Health (1994c) claimed reallocation of resources from hospitals to community-based care was central to preserving medicare. Prior to 1992, health care dollars were channelled into hospital-based and physician-directed acute care with the traditional curative focus on client behaviours and institutional treatments. The Working Group on Health Services Utilization (1994) recommended continued cutbacks in hospital and acute care services and a transfer of care and funds into the community. This documented proposal differed from the actual process of change.

As hospitals were undergoing rapid restructuring, the necessary infrastructure for community services was not yet in place in Ontario. Three years into the reform process a community health framework was still in the early stages of development (OCHU/CUPE, 1995). It appeared that instead of having more money at their disposal, overall spending in community and public health actually declined slightly from 1992 to 1994. A similarly inadequate home health care infrastructure was evident in the United States (Glazer,

1993).

Recent health care reform was also predicated on the assumption that cost-cutting and organizational restructuring were necessary to preserve medicare. Health care reform was promoted as proactive, driven by a changed vision of health (OMOH, 1992). The Ministry of Health acknowledged systemic barriers to affordable and accessible health care for women, children, the elderly, aboriginal peoples, and other segments of the population. To achieve better health for all Canadians, government documents advocated using resources more equitably and reordering basic features of Canadian society. For example, the Premier's Council on Health, Well-Being and Social Justice (1994) recommended assuring income adequacy, providing a safer ecosystem and improving political and cultural well-being.

Citing the Task Force Reports of the Cost of Health Services published in 1970, Campbell (1987) argued that cost containment had been the major preoccupation of policy makers since the advent of medicare. Those calls for reform aimed at reducing class-related inequities were echoes of those by Leonard Marsh in 1930s as well as the 1964 Royal Commission on Health Services. The Royal Commission on Health Services published in 1964 concluded that "we cannot ignore the unequal distribution of resources...; to meet our health needs... we are convinced that, however much we prefer voluntary to public action, nothing but public action and support at every level of government can correct the imbalance" (as cited in Badgley & Wolfe, 1992, p. 226). Badgley and Wolfe (1992) charged that other government initiatives such as the 1981 constitutional accord and closer economic ties with the United States were inconsistent with the government's plan to preserve medicare. Rather than reducing or eliminating

systemic barriers, these policy positions promoted greater rationalization and privatization of health services.

Finally, health care reform was predicated on the assumption that escalating health costs did not translate into improved health status for the Ontario population (OMOH, 1992). A provincially-funded report by the Premier's Council on Health Strategy (1991) found no positive correlation between increased spending on formal health care and improved health status. The ministry adopted the World Health Organization definition that health was "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" (OMOH, 1992, p. 3). The government cited countries like Japan and Sweden where health status improved when public policy changes impacted on the determinants of health like accessibility of health care, education, environmental and socioeconomic factors. Reform initiatives examined the major determinants of health, all of which lay outside direct health care delivery. Wealth and Health; Health and Wealth (1994) was one example of a government-funded study which investigated beyond the boundaries of traditional health care exploring social, economic, and environmental determinants of health.

The ministry (OMOH, 1992) admitted there was an inappropriate emphasis on institutional and doctor care resulting in escalating costs. Prior to 1992, health care dollars were channelled into hospital-based acute care where the emphasis was on traditional curative health care emphasizing personal behaviours and institutional treatments. The Working Group on Health Services Utilization (1994) recommended cutbacks in services and a transfer of care into the community. Although hospitals were characterized as inefficient and risky places to obtain health care, the health care

administrators and physicians who prepared the report did not recommend ways of correcting these problems. The move to reduce inpatient care and increase outpatient services intensified, rather than reduced, problems with institutional care (Armstrong, 1995b; Armstrong, Choiniere, Feldberg & White, 1994; OCHU/CUPE, 1995)

The government shift in emphasis from cure to prevention and from acute care in hospitals to health promotion has been characterized as shifting from "the cuts and chemicals to the carrots and condoms approach" (Armstrong, 1995b, p. 5). The language and the evidence echoed that used by left wing lobbyists who for years fought for progressive change. Rekart charged the left and right "are virtually indistinguishable" (as cited in Armstrong, 1995b, p. 16) in their language of support. Despite the apparent similarities in the left wing push for progress and reform, there were "vastly different operational and practical implications for opposing sides" (Armstrong, 1995b, p. 5).

This body of literature suggested that the assumptions upon which recent health reform in Ontario were predicated were either false or misleading. There were also incongruities between the proposed process and the actual practice of change implemented by the Ontario Ministry of Health to achieve the goals of reform. Improved coordination of all health care services was proposed to ensure that the right service was available at the right time in the right place to meet consumer needs. To introduce the necessary changes and achieve these goals the Ontario Ministry of Health (1993) promised to work "in partnership with health care providers, consumers and other ministries" (p. 25). The central partnerships formed by the ministry were, however, reincarnations of pre-existing bureaucratic linkages.

Most key partnerships between the Ontario Ministry of Health and stakeholders

were established in 1991 early in the reform process. One such partnership, the Joint Policy and Planning Committee (JPPC), linked the Ontario Medical Association (OMA) with the Ontario Hospitals Association (OHA). The OMA/OHA JPPC brought together the three parties with the greatest investment in the existing hospital structure and accorded them the most powerful forum for decision making and major policy discussion (OMOH, 1993).

In contrast, nursing representation was conspicuously absent from central roles like those accorded physicians, as noted with the example of the OMA/OHA JPPC. This was remarkable given that nurses constituted the largest segment of health care providers. Glazer (1993) found that women and nurses in the United States have been unable to influence state and corporate policies related to health care. The same was true in Ontario. While it may be argued that the ministry established links with nurses at the provincial level, an examination of three mechanisms extended to nurses illustrated that these were limited partnerships. The power of these groups to effect change was limited by resources, ineffective mechanisms for input, and token representation in decision-making roles.

In 1991 the Ontario Ministry of Health formed a Restructuring Subcommittee comprised of nurses and other representatives of labour. The Restructuring Subcommittee reported to one of ten subcommittees which in turn reported to the OMA/OHA JPPC. The impact of any recommendations forwarded by nurses was significantly weakened before reaching this central decision-making body.

In addition to token representation on the Restructuring Subcommittee, the Ontario Ministry of Health also set up a series of Nursing Focus Groups. The Ontario

Ministry of Health (1993) described these meetings with nurses as "think tank" (p. 7) sessions for "discussing issues facing nursing" (p. 7). This characterization of the "partnership" extended to nurses clearly indicated this was neither a forum for decision making nor policy discussion. Again, nurses were not extended the same power or mandate as other stakeholders such as physicians.

Some nursing leaders believed the government used the size and diversity of their occupational group as an excuse not to consult more extensively with nurses. Angus (1995) quoted one nursing leader saying,

> And the big issue there was who do you consult within nursing? Do you consult with the RNAO [Registered Nurses' Association of Ontario], do you consult with ONA? And the whole issue of who's really speaking for nursing became a good excuse for government not to have to listen to what nursing says. (p. 8)

The Joint Provincial Nursing Committee (JPNC) established in 1994 appeared to grant nurses fairer representation in planning and decision making. The JPNC was established by the ministry in response to lobbying by the Ontario Nurses' Association (ONA) and was characterized as a forum for discussing issues like health care reform and human resources planning ("ONA protests lack of labour input...", 1994). According to an ONA official (S. O'Neill, personal communication, July 5, 1995), the government did not grant JPNC the same financial resources and advantages enjoyed by other committees in partnership with the Ministry of Health. After 14 months, the JPNC disbanded, and with it ended official participation of nurses in health care reform at the provincial level.

Nursing participation in the process of reform at the local or hospital level was also limited. Baumann, O'Brien-Pallas, Deber, Donner, Semogas and Silverman (1995) found

significant differences in the way administrators and nursing staff defined job loss and described the process of hospital downsizing and the degree of staff involvement in the process. Some administrators perceived little value in staff nurse involvement in planning and decision making while others who espoused the need for a cooperative decision making actually used a top-down management approach. Not surprisingly, staff nurses perceived their participation in decision making was non-existent, meaningless, or restricted to representation on token committees. Baumann et al. noted that their findings may actually understate the real extent of problems identified by staff nurses.

The central partnerships between the government and stakeholders were not consistent with the language of change used in Ministry documents. Instead of effecting change, the partnerships recreated pre-existing bureaucratic alliances and furthered the right wing political agenda. Nurses were not viewed as partners in reform and were not accorded a consultative role commensurate with the size of their professional group either at the provincial or the local level. Although it may be argued that partnerships were established, the power of these groups to effect change was limited by resources, ineffective mechanisms for input, and token representation in decision-making roles.

The government claimed reforms were aimed at preserving medicare. After three years into the five-year reform process, government reform initiatives were shifting health care toward a two-tiered system where those who could afford it would get quality care; and those who could not, would not. Literature critical of health care reform proposed the shift toward privatizing care was part of a larger agenda to dismantle the welfare state (Armstrong, 1995b; Lexchin, 1994). While the Ontario Ministry of Health claimed privatization of care was about increasing choices by empowering consumers and health

care providers, Armstrong (1995b) contended privatizing services was really about power and money. There appeared to be similarities between the processes and outcomes in the American health care system (Glazer, 1993) and those of Canadian health care reform (Armstrong & Armstrong, 1994b; Campbell, 1987; Yyelland, 1994).

Armstrong (1995b) defined four kinds of privatization, three of which are relevant to this discussion. The first, mentioned earlier in this discussion, was an ideological shift to the discourse, techniques and technologies of the private sector. One of the overall outcomes of using business terms and practices to redefine the goals of hospitals was the displacement of the more traditional goals of health care delivery. The Ministry of Health (1992) described and measured goals in terms of effectiveness, efficiency, and productivity. Hospital restructuring took the form of shorter patient stays, increases in day surgery, and higher patient turnover (OCHU/CUPE, 1995; Working Group on Health Care Utilization, 1994). The ministry also advocated exploring options for stimulating economic growth through investment in medical technologies and stimulating employment opportunities for regulated health care professionals in the private sector (OCHU/CUPE, 1995).

A business focus on improving efficiency and profit was used to justify the shift in health care provider from public non-profit provision to private for-profit provision (Armstrong, 1995b; Glazer, 1993). This was the second form of privatization. Larson and Tate (1995) found that rather than promoting consumer empowerment, this form of privatization created systemic obstacles which actually limited consumers' real choices about appropriate health care. Ministry cutbacks in public acute care services have caused long waiting lists and indirectly contributed to the growth of the private sector (Armstrong

et al., 1994; OCHU/CUPE, 1995). When consumers have not been able to get services from public facilities, they have been increasingly forced to pay for private services. Those who could afford to pay for private sector services had greater access to health care than those with limited resources (OCHU/CUPE, 1995).

Studies of the American health care system (Glazer, 1993) also indicated there was no evidence to support this shift into the private sector. Rather than generating the promised cost-savings, the use of business principles resulted in higher health care costs and an increased emphasis on the medical model. The business focus transformed care for clients into concern for costs, transformed caring labour into part-time, insecure work, and eliminated jobs and public hospitals.

Privatization of care has also taken another form which Glazer (1993) claimed has reshaped the workplace and family life. Cost-containment and rationalization of services has been used to justify shifting the direct financial costs of caring for the sick from the government to the private sector and from the public to the private sphere. Reform initiatives have eliminated nursing positions, consolidated jobs, redesigned the work process and emphasized technology (Cameron, Horsburgh & Armstrong-Stassen., 1994). While hospitals have appeared to be more efficient and less costly, the labour and its costs were not eliminated. Armstrong (1994) and Gregor (1995) claimed that less visible financial and psychological costs have been shifted from paid women (nurses) to unpaid women (mothers, wives, daughters). This shift has occurred without fully investigating the benefit or harm to the medical, social and psychological health of either the patient or caregiver (Armstrong, 1994; Armstrong, 1995a; Armstrong, 1995b; Glazer, 1993).

Glazer (1993) claimed that reassigning work from the hospital to the home and

from paid skilled labour to unpaid family members was driven by economic considerations. "Work transfer" was the term Glazer (1993) coined to refer to "a process that originates in the effort of employers to rationalize the use of labour" (p. 28). Reform initiatives have appropriated women's unpaid work to complete labour processes begun by paid workers. In this way, work transfer reduced hospital labour costs, increased revenues in the private service economy and contributed directly to the well-being of the economy (Glazer, 1993).

Organizational restructuring, privatization of care and the emphasis on the discourse and practices of business have impacted on the nature and distribution of nurses' work. Support for cost containment and the rationalization of services has been voiced by some nursing academics (Baumann et al., 1995; Cameron et al., 1994) and unions (O'Neill, personal communication, July 5, 1995). Returning primary responsibility for the care of the sick to the home and family has been justified on the basis of medical and moral benefit to the family (Gregor, 1995; Wizowski, 1994). This submerged the cost-cutting agenda of privatization. Others have argued that the Ontario government agenda has also eroded the visibility and importance of nurses' traditional work (Angus, 1995; Glazer, 1993; Gregor 1995). Privatization decommodified women's paid labour and made women's caring work invisible by blurring the boundaries between the public and the private spheres. This leads to the next section and a review of literature that explores how nurses and nursing labour have been affected by reform initiatives.

Nurses and Nursing Labour

The previous section presented a macro analysis of the assumptions, process and

outcomes of health care reform highlighting the shift toward privatizing health care delivery. This section reviews literature which examines the historical, structural and ideological forces that have shaped nursing labour and nurses' subordinate location in the health care system. Five themes have emerged: (1) the context of societal patriarchy and bureaucratic discourse; (2) the influence of government policies; (3) the historical roots of nursing in the ideologies of femininity, domesticity and motherhood; (4) the educational experiences of nurses; and (5) the push toward professionalism in nursing.

Nurses and nursing labour have been constrained by their location within a patriarchal society. Levine (1989) wrote, "The hospital is a microcosm of male authority and female subservience (patients and staff) that is endemic to patriarchal institutions, structures and organizations" (p. 239). It has been within this context that nurses have worked and have been accountable to patients, physicians and management (Campbell, 1987; Wotherspoon, 1994) and to the public (College of Nurses of Ontario, 1990). Studies of the experiences of minority groups reviewed by Mills and Simmons (1995) have indicated that bureaucracies usually mirror the prejudices of the larger society. Nurses' subordinate position in health care mirrors women's position in societal patriarchy.

Bureaucratic discourse has also shaped nurses' position in the health care system. Bureaucratic discourse, which has stressed rationality, objectivity, impersonality and business values (Ferguson, 1984; Mills & Simmons, 1995; Yyelland, 1994), has been associated with men and maleness. Nursing, which has its roots in domestic discourse, (Achterberg, 1990; Coburn, 1987) has stressed subjectivity and caring values. Nursing has also been associated with women and femininity. Men have been seen to have appropriate characteristics to function well within bureaucracies. Women, on the other

hand, have generally been seen to lack the appropriate characteristics, and have therefore been largely excluded from bureaucratic life or restricted to lower levels within hierarchies. The more valued members of a bureaucracy have been managers who have had comprehensive power to define and control all aspects of bureaucratic structure, policies, practices and the organization of labour. The inequities in power and opportunity for women within hierarchies have signalled to them that they are less valued members in organizations (Mills & Simmons, 1995).

Traditionally, the curing aspects of healing have been associated with men and they have tended to obtain autonomy, status and power in health care organizations. Technical skill and knowledge derived from medical practices have been highly valued socially and economically. The caring aspects of healing have often been associated with women and they have tended to obtain positions of dependence and subordination in health care organizations. That nurses have not been highly valued is evident in their relatively low wages and status, their lack of control over their day-to-day labour and their lack of professional autonomy (Campbell, 1987; Wotherspoon, 1994). Caring skills without roots in physician-driven knowledge have been considered "natural" or "common sense," and have been accorded little or no social or economic value (Achterberg, 1990).

The gendered concept of "skill" has been frequently used to exclude women's labour from categories of skilled work (Cockburn as cited in Mills & Simmons, 1995). "Deskilling" of nursing labour has been evident historically through a number of administrative policies (Campbell, 1987). Patient classification systems adopted by Canadian hospitals in the 1970s were promoted as tools for assessing patient care needs and ensuring adequate staffing but have also served to measure time and motion efficiency

(Yyelland, 1994). Detailed policies and procedures supposedly developed in the interest of standardization and efficiency often have dictated how a nurse could perform every aspect of her role. Quality assurance activities have been used to monitor every aspect of nursing labour (Campbell, 1987). Job redesign has fragmented patient care and has reassigned certain aspects of labour to generic workers. The cumulative effect has been to secure the powerful position of managers in the hospital, and to limit nurses' control over their work by making them increasingly subject to management control (Wotherspoon, 1994). The detailed division of labour and the process of "deskilling" have been part of a trend toward cheapening labour (Duffy & Pupo, 1992).

The historical devaluing of nursing skill can be equated with nurses' relative powerlessness. Gaskell (1992) wrote, "Only if skill is translated into power in the work-place does it result in higher wages" (p. 147). During the first half of the twentieth century nurses struggled to establish an adequate salary (Colliere, 1986). Significant wage differences in comparable and equal jobs continued until recently (Achterberg, 1990). Jobs held by women paid less than comparable hospital jobs held by men. Pay equity legislation in Ontario was implemented in most hospitals in the early 1990s resulting in significant wage increases for nurses. It was about this time that hospital reform in Ontario initiated the displacement of hundreds of Registered Nurses.

Some studies (Dalton, 1990; Kerr as cited in Wotherspoon, 1994) have noted increasing militancy among nurses. Historically, however, nurses have been unable to form a strong and effective collective response to management control over the organization of their labour, and wages. Achterberg (1990) posited that nurses who have been socialized in a hierarchical power-based bureaucracy have learned only two

behaviours: the aggressive power stance of their oppressor and their own deferential demeanour. She claimed that when victimized or demeaned by individuals or the system, women often lashed out, not against their oppressors, but at each other. These behaviours were similar to the description by Mills and Simmons (1995) of minority group behaviour, and Yyelland's (1995) correlation between men's acts of violence against women in society and the individual and systemic abuse of nurses.

Nurses' subordinate position in health care has also been constrained by government policies. Legislation such as the 1984 Health Care Act and the more recent Regulated Health Professionals Act (RHPA) in Ontario have reinforced the dominance of the medical model in the health care system. The Ontario Ministry of Health (1993) claimed the purpose of the RHPA was to provide a basis for developing new ways of reorganizing and delivering services. The Final Report on the Nursing Roundtable (OMOH, 1994b) suggested that some nursing leaders supported the RHPA in principle. Angus (1995) argued that the very structure of RHPA reinforced the power of physicians, devalued and limited the growth of other health disciplines and contributed to a deprofessionalization of nursing practice. The act failed to recognize the concrete and abstract functions central to nursing and reflected societal norms that work based on caring, (work predominantly performed by women) was not to be valued or rewarded. Rather than ensuring access to the health profession of the client's choice, the RHPA protected physicians' power and status within health care system by reinforcing the medical model.

The RHPA may be viewed as part of the ministry's plan to influence the distribution and practice patterns of health care providers. The Ontario Ministry of Health

(1993) expected to influence the reorganization of work processes based on established health outcomes and the documented needs of the population. Glazer (1993) has noted that similar initiatives in the American health care system have impacted most acutely on women and nurses. The following research suggests the same may be said for Ontario:

Hiscott's (1994) quantitative analysis of employment mobility among Ontario nurses noted changes in the distribution of nursing labour. He examined a variety of changes in employment status including both job loss and the shift from full-time employment to part-time employment. White's research (as cited in Hiscott, 1994) showed part-time employment in nursing was growing much more rapidly when compared with overall part-time employment in Canada. A reduction in hours negatively affected the income and benefits and the degree of autonomy and control nurses had.

The consequences of the shift from full-time to part-time employment also reflected the marginality of nurses' work role (Hiscott, 1994). A study of casual part-time or temporary employees suggested these workers received inferior treatment under the law when compared with full-time employees (England as cited in Hiscott, 1994). Legal regimes that govern work relations like individual employment contracts, employment standards legislation and the collective bargaining legislation provided less protection for part-time workers.

The Working Group on Health Services Utilization (1994) recommended that nurses become "less specialized" and "more generic in their approach to their jobs" (p. 34). In an article published in Nursing Times, Cohen (1994) recommended that displaced nurses broaden their search geographically, and look outside their area of specialty. They were also encouraged to reduce their expectations regarding salary, job fit, hours of work,

and job satisfaction.

These statements implied that the specialization of nursing practice was not viewed by government and other health care partners as essential to the delivery of quality acute care services. It also assumed that nurses' skills and knowledge were readily transferrable across settings. Asking nurses to expand their job search geographically mistakenly assumed that nurses, mostly women, were unencumbered by family and other responsibilities and free to move in search of work. Hiscott (1994) argued that this was not the case. Finally, these government recommendations assumed nurses' expectations for salary and working conditions had been too high, and the value of their labour did not justify these expectations. Nurses were being asked to accept less, and not to expect others to value their contributions to health care delivery. The penalty for resisting these changes was unemployment. Accepting these conditions reinforced the devaluing of nursing labour and nurses' subordinate position in health care.

The devaluing of nursing labour also had it roots in the historical development of nursing from ancient to modern times. The barriers to autonomous practice have been related to the "weight of past tradition" (Achterberg, 1990, p. 177) and an educational curriculum for nurses that reproduced the religious and social agenda of subordinating women in society. The powerful role of woman as healer existed in many cultures and changed over time. Records of nursing as an occupation date as early as 700 B.C. (Achterberg, 1990). Gradually over several centuries women's central role as a healer in our culture was lost as nurses and wet-nurses became servants to the wealthy and powerful. As nurses lost their social status, nursing lost its importance, and little more was written about nurses until medieval times.

In medieval Christian history, the role of healer was divided into curing activities carried out by men and caring services provided by women. During the Crusades the first major system of hospital care was established. These hospitals were staffed by an estimated 200,000 women largely serving within the Church. Some viewed these monastic nursing orders, most notably the Augustinian sisters, as a move toward an occupational identity and "the advance guard of woman's emancipation" (Achterberg, 1990, p. 51). Others who recognized the unequal power relation between the nursing sisters and monks regarded these nursing orders as "the advance guard of woman's bondage to a male-dominated system of health care" (p. 51).

For centuries, the importance of the Church's position and teachings served as both a strong theological and scientific basis for limiting women's position and practice of health care. A woman's body, once a symbol of fertility and healing, became associated with sexuality, sin and evil. Virginity, a symbol of denying sexuality and the body, became a desirable state for women. In the case of nursing sisters, all consecrated virgins, caregiving was the path to salvation (Achterberg, 1990). Through the language and imagery of Church teachings all other women caregivers became associated with corruption and demonic powers (Colliere, 1986). Thus began the separation of healing practices into caring and curing functions. Women's health practices that were derived from women's knowledge of the body were condemned as pagan. In this way women were excluded from all health care practices associated with birthing, nurturing, and healing. Men's appropriation of women's knowledge was enforced by the genocide of hundreds of women during the era of the witch-hunts in Europe and North America. All healing practices were thus limited to, and controlled by, men.

From the sixteenth to the nineteenth century, arguments against women's greater participation in healing evolved with the scientific revolution. Arguments of that time related to women's biological weakness and mental deficiencies. These "scientific" arguments as well as religious and educational sanctions became the basis of arguments against women's professionalization (Achterberg, 1990). The movement toward a technological society and the separation of public and private spheres accompanied these changes. Women's role as healer was gradually redefined and developed alongside the ideology of domesticity (Achterberg, 1990). This ideology was well illustrated in the words and works of Florence Nightingale.

Nightingale (1820-1910) was a powerful force in shaping the way nursing has been defined today. Nightingale conceived of nursing as a "calling" not as a profession. With quotes such as "every woman is a nurse" (as cited in Achterberg, 1990) Nightingale reinforced the feminization of nursing and the view that nursing knowledge and skills were biologically determined. Because she conceived of nursing knowledge as innately feminine and nursing labour as akin to mothering, she argued against the professionalization of nurses saying it was as inappropriate as examining or licensing mothers (as cited in Achterberg, 1990). While she elevated nursing to a respectable female occupation, nurses' knowledge, skill and caring labour were devalued in the same way domestic work and mothering were devalued.

Prevailing norms about women, caring and family also constrained women's movement into the public sector. Women looking to work outside the home were often channelled to roles consistent with these norms. This was exemplified by the 1916 Report of the Ontario Commission on Unemployment which promoted nursing as ideal training

for marriage and mothering (as cited in Coburn, 1987). Nurses' labour, often time consuming, repetitive and tedious replicated the everyday life of women in the private sphere (Coburn, 1987). Until the 1930s nursing in Canada had more in common with domestic labour than with any other occupation (Wilson, 1991). Nurses also filled those niches left open by men and medicine. For example, the Victorian Order of Nurses enunciated women's social and moral responsibility for children, a previously neglected area of health care. The mission of these nurses extended women's mothering into the community (Scott, 1995; Wilson, 1991).

Nurses' education throughout this century has also reinforced the subordinate position of women in health care. During the first half of this century young women were taught the moral laws and obligations that governed a nurse's behaviour. These rules were presented as necessary "to maintain the standard of the profession at a high level" (Maxwell & Pope, 1923, p. 13). Nurses were trained to demonstrate "prompt unquestioning obedience" (p. 11) in their relationships with the hospital and its authorities and physicians. Nurses were expected to refrain from "grumbling and adverse criticism of those in authority" (Maxwell & Pope, 1923, p. 13). Even the language used in this example illustrated the unacceptable and frivolous nature of any concern a nurse may have raised about the system, the rules or those in authority. Appropriate behaviour included assuming "a deferential attitude... when receiving orders or instruction from one in command" (p. 11). Nurses were expected to read psychology textbooks to develop "the ability to read character quickly" so they could say and do "the right thing at the right time" (p. 7). Other acquiescent female attributes such as "orderliness" (p. 6) and courtesy" (p. 7) complemented the ideology of femininity which restricted women's work

outside the home to domestic duties (Coburn, 1987). To this day, nurses have, at times, referred to their relationship to a doctor as that of a handmaiden (Glazer, 1993; Wotherspoon, 1994).

Nurses' education has also reflected the expectation that nurses use, and regulate the expression of emotion. Balancing sympathy with self-control was integral to the performance of a good nurse.

> The constant contact with suffering, the necessity to exert self-control at all times, and to get through with the work no matter what happens, does tend to make those in a hospital forget that an occasional expression of sympathy and encouragement is often sadly needed, by both patients and fellow workers. (Maxwell & Pope, 1923, p. 8)

This had been noted today. James explained that an essential element of nursing has involved "dealing with other people's feelings, a core component of which is regulation of emotions" (as cited in Yyelland, 1994, p. 232). While it was seen to be a nurse's responsibility to "maintain harmony and cooperation among patients and health care providers" (Yyelland, 1994, p. 231), emotional labour or caregiving was not valued. Western culture has not tolerated or valued the expression of emotion and has perceived emotionality in the workplace as counterproductive (Angus, 1995). As Campbell (1987) showed, performance evaluation tools emphasized and rewarded the development of a nurse's technical rather than emotional skills.

Nurses' education has also promoted the duty or obligation to care. As previously discussed, nurses' role has been shaped by religious teachings and sanctions. Colliere (1986) claimed that a nurse's obligation to physicians and devotion to patients also had

religious underpinnings. The expectation of a nurse's unselfishness was apparent in this admonition: "Almost any question of one's obligation to others can be answered by the application of the Golden Rule" (Maxwell, & Pope, 1923, p. 14). Unselfishness was demonstrated by "rendering services that they do not consider 'their work'," and by a willingness to "stay on duty longer than their legitimate time" (Maxwell & Pope, 1923, p. 9). Identifying reasonable limits to hours of work was considered selfish and brought "discredit upon the profession as a whole" (p. 9). Student nurses who were not prepared to do so were advised to "prepare for some profession in which they can stop work on the stroke of the hour, for they will never be able to count on doing so when caring for the sick" (p. 9). Unfinished work has been considered the fault of an unorganized or inefficient nurse rather than inappropriate staffing or an unreasonable workload (Campbell, 1987; Maxwell & Pope, 1923). Developing this moral perspective ensured that problems were depoliticized as personal failures unrelated to systemic issues. If a nurse did not accept her subordinate position or voiced her concern, this was treated as a personal rather than a structural problem (Campbell, 1987).

Nursing education emphasized moral laws and obligation above knowledge and technical skill. During the first half of the century, Coburn (1987) claimed that a nurse was expected to be knowledgeable enough to accomplish her duties but not so knowledgeable as to challenge the medical model. Knowledge was considered third in importance after learning "the right mental attitude" and developing the ability to "inspire confidence and liking in those with whom and for whom she works" (Maxwell & Pope, 1923, p. 3). Nursing education was hospital based and nursing students provided unpaid labour in exchange for their education (Coburn, 1987).

The movement to recognize nursing as a profession, which was first denounced by Nightingale at the turn of the century, resurfaced during the 1960s. The push to raise educational standards was aimed at promoting the ideology of professionalism (Glazer, 1993; Gregor, 1995; Wotherspoon, 1994) and protecting the title and diploma of nursing (Colliere, 1986; Gregor, 1995). During the early 1970s basic educational preparation in Ontario was moved from hospitals to college-based programs. In 1982, the Canadian Nurses' Association proposed that a baccalaureate would be the minimum requirement for entry into nursing practise by the year 2000 (as cited in Wotherspoon, 1994). Advanced preparation through to doctoral programs in nursing expanded in Ontario during the 1980s.

Appropriating a unique domain of knowledge was also perceived as necessary in the professionalization of nursing (Gregor, 1995; Wotherspoon, 1994). For the last 30 years the nursing academics have pushed to develop a scientific body of knowledge in nursing to complement the medical model of health care. Theory development that embraced scientific principles was expected to promote professional recognition and autonomy. The valuing of male over female knowledge typical of other educational curricula (Gaskell, 1992) was apparent in this proposed advancement of nursing knowledge.

Some have argued that nursing research has also been used to valorize the essential caring component of nursing in a culture which devalued emotionality (Angus, 1995). Although nursing academics claimed to operate from an ideology distinct from the medical model, Angus (1995) argued that nursing was sometimes viewed by the government and the public as a cheaper form of medical services. "It was hardly necessary to justify low

wages for nurses when their work was considered a public service and similar to unpaid work in the home" (Coburn, 1987, p. 457).

Research that theorized nursing as health work contrasted sharply with the reality of nurses' work which was caring for the sick in hospitals (Gregor, 1995). While Angus (1995) wrote that "nursing operates at the borderline of an ideological shift in health care" (p. 2), Gregor (1995) concluded that "the majority of nurses, whose work is demonstratively about sickness and disease, are being 'reformed' out of existence for want of a strong and coherent defense of what they do" (p. 16).

Nursing leaders may have been responsible, in part, for undermining the stability and centrality of caring work. The Final Report of the Nursing Roundtable (OMOH, 1994b) acknowledged the alignment between the ministry's vision of health and nurses' holistic approach to health care and health promotion. These ideologies of client self-care, client autonomy, empowerment and personal responsibility have been increasingly prevalent in Ontario nursing curricula (Campbell, 1987; Wotherspoon, 1994), hospital mission statements (Wizowski, 1994) and reform initiatives (Premier's Council on Health Strategy, 1991; Working Group on Health Services Utilization, 1994). Glazer (1993) claimed that nursing, the state, and corporate leaders used these ideologies to justify labour reorganization in the American health care system. While the professionalists were promoting independence in nursing practice (Wotherspoon, 1994), the bedside nurse was being "deskilled" and displaced. Gregor (1995) argued that the ideological alignment between the government agenda and nurses' holistic approach to health care and health promotion was an illusion. The drive to elevate the professional status of nurses was not reflected in improvements in their wage, working conditions, autonomy or control over

their labour.

Recent studies of health care workers who retained employment pointed to the negative impact of health care reform. There was a contracting pool of qualified specialized nurses, a decreasing college intake leading to a decreasing supply of nurses and an increasing demand on the part of management for skill-mix in staffing. Dickson (1993) confirmed the trend from professional to less qualified health care personnel and the trend to skill-mix. Job speed-up, perceived declines in the quality of patient care and fear of job loss were documented in studies of hospital nursing personnel (Glazer, 1993). In a study of the quality of hospital worklife, Cameron et al. (1994) found nurses as a group were especially vulnerable to the negative effects of downsizing. This finding was attributed to several factors including increased workload, relocation to less preferred work, heightened job uncertainty, feelings of powerlessness, perceptions of lack of organizational support, and lack of opportunity for influencing the outcome of organizational change. Understaffing and higher acuity levels impaired the health and well being of nurses who retained employment (Yyelland, 1995). Almost a decade ago Campbell (1987) noted that nurses had been required to absorb a disproportionately heavy burden of cost containment. Campbell (1987) and Yyelland (1995) have argued that this must be seen as a gender-specific form of oppression.

While there was a large body of literature (Burman, 1988; Davies, 1996; Grayson, 1993; Human Resources Development Canada, 1994; Leventman, 1981) devoted to the study of workers impacted by job loss, there has been little written about Registered Nurses displaced by hospital reform. In a study of laid off hospital workers in Ontario, Grayson (1993) reported nursing was the occupational category hardest hit by temporary

and permanent layoff from employment. He also concluded that nurses were not adjusting economically to job displacement. Registered Nurses showed lower rates of re-employment than other occupational groups. Among the re-employed, one third were earning less than in their previous job and almost half believed their new job required more skill than their previous job. Grayson also reported that the longer a worker remained unemployed, the less likely she was to find re-employment. It also appeared training was unrelated to an individual's ability to become re-employed. Based on Grayson's work and other internal and external reviews, the Hospital Training and Adjustment Panel (1993) concluded that aiming government resources primarily at retraining laid off workers was an ineffective strategy for supporting labour adjustment.

There was a paucity of literature describing the experience of job displacement from the perspective of the Registered Nurse. Displaced nurses in Ontario have not been asked about their experience of unemployment or about how they have made meaning of the health reform initiatives affecting their lives and work. A few displaced nurses have published their stories in nursing journals (Cavanaugh, 1994; Dahlstrom, 1994).

These nurses have talked about the anger, disillusionment and grief they experienced after their layoff. Loss of safety and security, loss of professional identity and belonging were listed with shock, confusion, self-doubt, embarrassment, humiliation and feelings of isolation as common reactions to job loss. Dahlstrom (1994) characterized her layoff as a "slap in the face, an attack on who you are and all you've done" (p. 84). Cavanaugh (1994) described her job loss as "being in the wrong place at the wrong time" (p. 66).

Some nurses blamed managers and the government for their loss of job and status.

Cavanaugh (1994) voiced concerns about the impact of health care reform on patient care, claiming that the public was losing the special knowledge and skill of nurses. While she acknowledged that layoff decisions were at times politically driven, she admonished displaced nurses to "control the impulse to strike out or to burn bridges. You never know who'll be giving input into the hiring process for your next position" (p. 70). While anger was considered natural and necessary, Dahlstrom (1994) counselled displaced nurses against writing letters that might affect their employer references. Legal action was also discouraged with the advise "living well is the best revenge" (Zimmerman, 1994, p. 128). Nurses were also advised by other nurses against acting or admitting to feeling ashamed. "Others take your lead and assume you're guilty" (Dahlstrom, 1994, p. 87).

Other articles (Dickson, 1993; Zimmerman, 1994) published in nursing journals also advised displaced nurses on ways of responding to job displacement. Citing shrinking hospital budgets, reduced funding to hospitals, flattening organizational hierarchies, elimination of mid-management, decreasing hospital occupancy and a decreasing number of acute care settings, nurses were advised that finding re-employment in a hospital was unlikely (Carlisle, 1992). Looking for a nursing position outside a hospital, retraining in another nursing speciality, undertaking an entrepreneurial endeavour, or pursuing a new occupational avenue were all considered reasonable alternatives to bedside nursing. Nurses were encouraged to maintain links with colleagues and the displacing employer since this might be a source of future employment opportunities. Engaging in volunteer or part-time work was also viewed as a means of restoring self-esteem and financial stability for those faced with extended unemployment.

Displaced nurses and those anticipating job displacement were told to accept the

reality and inevitability of restructuring and layoffs. Zimmerman (1994) advised, "Believe and prepare for the possibility.... Don't make work your home" (p. 127). As job security has become a thing of the past, nurses were advised to focus on their career and profession, not on institutional loyalty. Nurses were advised to enhance their personal value to the organization by keeping abreast of buzz words and trends, learning a second language, computer skills, technologies, new and different professional responsibilities.

The Explanatory Power of Structural Analysis and Human Agency

Structural analysis has emphasized social, political and other constraints to social action. An example of such analysis was drawn from Mills and Simmons (1995) as they claimed "organizations permeate nearly everything we do. They shape the way we live, the way we think, the way we are valued and the way we value ourselves" (p. 5). Structural constraints can be argued to have affected the nurses and nursing labour. Such constraints have included societal patriarchy, government policies, administrative policies, nursing education and the professionalization of nursing. Ideological conflicts can also be argued to have affected nurses and nursing labour. One example of such a conflict was that between caring and curing. In emphasizing the power of such forces to dictate social action, we must be careful to avoid characterizing nurses as victims without some freedom or power to make choices or shape their destiny.

Explanations that incorporate human agency in contrast to those about structures stress the ability of individuals to resist. Gaskell's (1992) study of social reproduction in schools was "shaped by a desire to emphasize human agency in the context of structural analysis" (p. 134). This postmodernist approach combined macro and micro perspectives

to study girls' choices and chances in moving from school to work. The result was an understanding of the gendered self as it was created in and through organizational discourses. Ferguson (1984), another postmodernist, has offered a view of the self as situated socially and temporally, and as an "evolving outcome of the interaction of possibility and circumstance" (p. xiv). Blending of the power of structure to constrain social action and the power of the individual to exercise some control and make choices about action offers another way of explaining the complexities of social action and the nature of power relations.

Summary of Literature Reviewed

Health reform initiated in Ontario in the early 1990s has resulted in hospital downsizing and the displacement of hundreds of Registered Nurses. Patterns of institutional restructuring may be understood as the interplay among economic changes, the role of the state, institutional discourse and practices, and social reproduction within the public and private spheres. Literature critical of health care reform has challenged the assumptions, processes and outcomes of reform initiatives. Because nurses were not viewed as partners in the process, despite the size of their occupational group, they have been unable to influence state or corporate policies. Cost containment and rationalization of services have been used to justify the substitution of more cost effective forms of labour. One result of restructuring has been to confine women to the margins of the labour market with lower paying and insecure part-time work. Government and hospital initiatives to balance the budget have shifted more responsibility for health care to private industry and to the private sphere. Government and hospital initiatives also have altered

the nature and utilization of nursing labour. Full-time Registered Nurses have been permanently displaced or re-employed as part-time workers and replaced by a less expensive category of nursing labour. These changes have coincided with "deskilling," intensification of work, fragmentation and increasing managerial control over work processes, and an increasing emphasis on technical skills and de-emphasis on emotional labour.

Health care reform and the reorganization of work processes have reproduced the historical devaluing of nursing labour and have been facilitated by the subordinate role of nurses and women in the health care system. Feminists have explored how gender impacts nurses' access to power and position, and the separation and valuation of caring and curing functions. Nursing and nursing labour have been shaped historically by economic, political and religious forces, and reinforced by the ideologies of femininity, domesticity and motherhood. Occupational subordination and segregation were also reinforced by educational experiences and legislation which empowered physicians and limited the power of nurses in institutions and in practice. Devaluing of nursing labour came from the belief that skills and knowledge associated with nursing were innate or natural, and therefore of less value. Another explanation was that the dualistic nature of nursing labour, technical and emotional, has been difficult to quantify and evaluate given the gendered definition of skill.

Much of the academic literature presented here focused on structural constraints guiding health care reform and affecting nurses and nursing labour. By contrast, the works published by displaced nurses focused on the power of the individual to respond to job loss and find work in a changing bureaucratic structure.

CHAPTER THREE: RESEARCH METHODOLOGY

Introduction and Overview of the Chapter

This study identified and explored some responses of Registered Nurses to displacement from full-time employment in general hospitals. This chapter explains the research methodology used to gather and analyze the data. A brief introduction to naturalistic inquiry precedes the discussion about the design and procedures. This is followed by a review of the assumptions and limitations of this study. Details of participant selection as well as an overview of the participant group are presented in the next section. The process of collecting, recording and analyzing data is explained in the last section. The main technique used for data collection was semistructured, individual and group interviews. Participants also completed a brief questionnaire. The three-step data analysis entailed: (1) identifying themes and patterns; (2) naming patterns and contradictions in meaning making; and (3) comparing findings to theoretical frameworks. This chapter begins with a clarification of changes from the original proposed study.

Process of Defining the Research Methodology

Although a mixed collection of quantitative and qualitative data was initially proposed, the final design did not include the quantitative component. My decision to use only qualitative research techniques was largely informed by a process of clarifying intellectual and political issues regarding social research. In this section, the emergent research design as well as the reasons for that change are explained.

For years, I had neatly separated my personal (feminist) ways of viewing and

explaining social action from the lens I used in my academic and professional endeavours. As an undergraduate student in sociology and as a nurse educator in a hospital, I participated in cultures that highly valued positivistic research. The courses I took and the professors with whom I studied emphasized the value and legitimacy of quantitative research. The nursing literature I read was replete with studies that used traditional research methods for the purpose of building and enhancing a "scientific" body of knowledge. As I perceived myself as holding less powerful positions in both these institutional systems, it seemed more prudent to neglect than to challenge the contradictions between my private perspective and the public one I felt forced to choose and use.

As a graduate student, I felt more supported by the academic culture and better prepared to address this conflict. In courses with Cecilia Reynolds and Alice Schutz I explored my interest in feminist methods in social research through group discussions and related readings. When I briefly engaged in story telling and journal writing as research methods, my views about collecting and analyzing research data were challenged. When writing my thesis proposal, I elected to incorporate qualitative data collection techniques as a way of learning more about naturalistic inquiry. In retrospect, I recognize that I was not entirely convinced of the "legitimacy" of qualitative methodologies. The proposed mixed methods design mirrored the conflict I had regarding the value, goals and purpose of qualitative and quantitative methodologies and my struggle with objectivity in research. Time constraints and logistical problems were ultimately the catalysts that helped me address that conflict.

The HSTAP database has been a centralized source of the most consistent and

comprehensive health-specific information and sub-sector data for Ontario containing information on over 14,000 displaced workers registered since 1991. Collecting data from this source was expected to serve three purposes. First, the data provided historical documentation of the demographic patterns of displacement among Registered Nurses in Ontario displaced from full-time employment by health care reform between October 1991 and October 1995. Secondly, I planned to locate the study participants within that Ontario snapshot of displaced nurses. Finally, drawing from patterns of unemployment and re-employment status, and pre- and post-displacement training, I planned to further develop my strategies for qualitative data collection.

From the outset, I experienced delays in setting up and running the programs for collecting quantitative data from the HSTAP database. Faced with the time constraints imposed for completion of the study, I proceeded with qualitative data collection before completing the quantitative phase as I had planned. After several weeks, it became clear that I was unable, even with the very able assistance of an HSTAP official, to develop a reasonable demographic picture of the historical trends in job displacement among RNs in the Ontario hospital sector. The data I generated were incomplete, or of limited value or both.

For my purposes, the HSTAP database was limited by three important factors (R. Mainolfi, personal communication, October 19, 1995). Statistical information about job displacement was limited to that which was provided voluntarily to HSTAP by hospitals and other health sector agencies. This meant that displaced workers employed by hospitals who were unaware of HSTAP were not included in the database. Secondly, files were further limited to those individuals who voluntarily registered for HSTAP services.

Those individuals who chose, for any reason, not to register or maintain their relationship with HSTAP were designated inactive files. In 1994, HSTAP mailed a request for information to all registrants. Files became inactive if registrants did not respond to the letter or did not access HSTAP services. A year later, the same procedure was repeated. Information on workers registered after 1994 tended to be more complete and accurate than data collected about registrants prior to that time. As a result, segments of the database were blank or inaccurate, or were designated inactive.

Finally, since the database was first established in 1991, there were changes in the ways data were collected. For example, prior to 1994, the data were collected only on hospital workers. Advanced and more powerful technology obtained in 1994 coincided with a shift to supporting labour adjustment across the health care system. The structure of the database, and number and coding of data fields changed (R. Mainolfi, April 9, 1996 personal communication). This created a problem when I tried to limit my search to a specific area in a subsector (general hospitals) and to a specific worker (Registered Nurses) in a specific role (staff nurse).

Given these logistical problems associated with using the HSTAP database, I elected to end further attempts to collect quantitative data from the HSTAP database. I briefly considered tapping other sources of subsector-specific information available from the Ministry of Health, Ministry of Labour, employer associations, unions and labour organizations and Statistics Canada. As Cairns et al. (1994) identified the limitations of these databases, I decided against these sources. I anticipated significant time and energy would be required to locate, collect and analyze data from another source such as publications and studies by academics, the government, and union and employer groups.

Given the compressed time frame I had for completion of this work, I decided to eliminate the quantitative data collection from the study.

This decision was made all the easier by the enthusiasm I had for the qualitative data I was collecting. During the time I spent in individual and group conversations, I developed a greater measure of comfort with the process and confidence with the findings. The nature and texture of these nurses' experiences were better reflected by the qualitative than the quantitative data. The emotional closeness I felt toward the participants enhanced my ability to investigate their political relatedness to their work and their employer as they felt and understood these connections. My readings of Lincoln and Guba (1985) and Reinharz (1992) addressed my academic concerns and infused me with confidence in the legitimacy and value of naturalistic inquiry. Finally, in reviewing my log of methodological decisions and rationales, and in discussions with my thesis advisor, I unearthed the political and gender issues that were central to my conflict. I concluded that while logistical problems and time constraints were the catalysts for change, this personal transformation (be it ever so modest) and the feminist perspective that informed it, were ultimately the forces driving my decision to focus on qualitative methods and naturalistic inquiry.

Naturalistic Inquiry, Research Design and Procedures

To understand responses to displacement in the ways they felt and understood them, I asked ten nurses to tell me about their job displacement and how this event affected their professional identity and perception of their work. My research proposal was reviewed and approved by the Brock University Standing Subcommittee on Research

with Human Participants (see Appendix A.). It also received the approval of the Executive Director of HSTAP (see Appendix B).

Data were collected using a questionnaire and through several individual and group interviews. Questionnaires were designed to collect introductory demographic data about the historical and social context of job displacement, and labour and economic adjustment. Individual interviews were an arena for individuals to relate their personal displacement story focusing on the social and emotional details of importance to them. During the two sets of group interviews, participants were able to reflect upon, question, analyze and discuss their own and others' assumptions, beliefs and understandings about the event.

The semi-structured format of the interviews provided direction while allowing for flexibility in data gathering. The questioning guides for each set of interviews were developed and shared with participants prior to the interviews. While the general research focus was established, I was open to other emerging foci as raised by the participants during the interviews. Graham advocated the use of semi-structured interviews as they permitted participants to be actively involved in "the construction of data about their lives" (as cited in Reinharz, 1992, p. 18).

A relaxed conversational format was used to facilitate the establishment of a warm, comfortable and trusting rapport between the individual participant and me, and among group participants. As time passed, I realized I was referring to the interviews as conversations. Using "conversation" instead of "interview," and "participant" instead of "respondent" or "informant" in my writing were feminist acts of renaming the conventional. Naming and renaming objects and processes resulted from ascribing

meaning that reflected one's personal reality (Reinharz, 1992). Not only did this more accurately reflect the content and the texture of the meetings, it also marked another step in my movement toward embracing naturalistic inquiry.

To provide a foundation for understanding the assumptions and limitations of this study, a brief comparison of naturalistic inquiry and positivism is incorporated into this discussion. While naturalistic inquiry has almost always entailed qualitative research methods, not all research involving qualitative methods adopted the principles of naturalistic inquiry. Naturalistic inquiry has been best understood as a paradigm built on a set of basic beliefs or axioms in the same way that positivistic research has been understood as a paradigm which presumed another set of beliefs (Lincoln & Guba, 1985). Assumptions about ontology (the nature of reality), epistemology (the nature of knowledge), generalizability, causality and the role of values in inquiry differed between the two paradigms.

Within the positivistic paradigm, there have been several criteria used to evaluate research operations and conclusions. The purpose of these criteria was to establish the trustworthiness of findings and interpretations. Validity, reliability, generalizability and objectivity were four conventional criteria. These measures were derived from the positivistic assumptive base and reflected the way knowledge was constructed in this paradigm. These measurements were essential to increasing the likelihood that positivistic research processes would render meaningful data and explanations.

At times, conventional criteria appropriate to positivistic research have been used to challenge naturalistic inquiry. Questions about validity, reliability, objectivity and generalizability were not appropriate criteria for evaluating the trustworthiness of

naturalistic inquiry. Lincoln and Guba (1985) explained that "different basic beliefs lead to different knowledge claims and different criteria" (p. 294). To be effective in measuring trustworthiness, evaluation tools had to share the same derivative relation to the knowledge they evaluated. Therefore, alternative techniques, those consistent with the naturalistic axioms, have been used in designing the methodology and challenging the findings of naturalistic inquiry.

This study incorporated four techniques consistent with naturalistic principles. Each increased the likelihood of gathering credible findings during interviews, and generating credible explanations for those findings. The first of these, prolonged engagement, required the researcher spend sufficient time with the participants to establish trust, learn the "culture" and test for misinformation and validate findings. This was achieved by meeting with the participants on three separate occasions over a six-week period for conversations lasting from 50 minutes to 2½ hours. My experience with being a nurse and being displaced gave me some insight into the culture, and enabled me to engage in shorter, more focused interviews (Reinharz, 1992). To build trust between the participants and me, and to establish a climate for sharing information, I disclosed my own experience with displacement both in writing and during the interviews. While self-disclosure has been accepted and even encouraged in feminist research, I was concerned some participants may have been distrustful of a nurse educator and a feminist. For that reason I downplayed my status in these regards.

The second technique I built into the research design was persistent observation. To satisfy this criterion I invested diligent effort in identifying those elements most relevant to the experience of job displacement. Data were reviewed and analyzed after

each set of interviews. Key factors were identified and explored in detail during subsequent interviews. Using prolonged engagement and persistent observation facilitated the collection of rich, thick data, that is to say, data with scope and depth.

Triangulation was the third technique used to establish trustworthiness by cross-checking or validating findings. Two modes of triangulation were used in this study. Source triangulation involved collecting data from more than one source. In this study source triangulation was achieved by collecting data from ten participants displaced from five practice settings in seven general hospitals located in three District Health Council regions.

Methods triangulation, the second mode employed, involved collecting data using more than one method. In this study, data were collected using a questionnaire and through several individual and group interviews. Participants provided demographic data about job displacement and labour adjustment. Individual interviews allowed participants to identify the factors shaping their own reality and group interviews allowed participants to reflect upon and discuss the context of shaping their collective realities. Using more than one source and method increased the likelihood of identifying pervasive themes and clarifying incongruities.

Considered by Lincoln and Guba (1985) to be the most critical technique for establishing credibility, member checking was the fourth technique used in this study to clarify and validate findings. The purpose of member checking was not to exact any "objective" reality but rather to facilitate the credible representation of the participants' realities. Member checking may also have contributed to building trust and a sense of collaboration between the researcher and the other participants (Lather, 1991).

To reduce the possibility of misinterpreting findings or misrepresenting data in this study, both formal and informal member checking were used. Formal member checking was built into the design by asking participants to review, edit and comment on the contents of their interview transcript. Informally, the researcher restated or paraphrased data during the course of individual and group conversations asking participants to validate or clarify their comments.

Assumptions and Limitations

Assumptions about generalizability, causality and objectivity were germane to this discussion. Positivistic research has aimed to generate precise conclusions that were generalizable to a larger group beyond those studied. These generalizable conclusions contributed to building a body of knowledge. Naturalistic inquiry, on the other hand, sought to build a body of knowledge through the comprehensive description and explication of individual cases. While positivism assumed that true statements could be generated which would hold anytime and anywhere, naturalistic inquiry assumed that knowledge was bound by time and context. Principles of naturalistic inquiry precluded the generation of generalizable truths (Lincoln & Guba, 1985). Commenting on her study of female hospital workers Sexton wrote:

> Generalizations can be misleading, inadequate, and lacking in any flesh and blood reality, they can also fail to take account of the astonishing variations among women and the work they do. Women have not one but many voices... . Both the themes and the variations, the individual and the collective voices need to be heard. (as cited in Reinharz, 1992, p. 4)

In naturalistic inquiry, all conclusions reflected the realities of those who participated and were understandable in the context of that particular case. In keeping with this principle, my aim was to document some responses to job displacement and offer possible explanations for my findings.

The two paradigms also differed in their belief about causality. The positivist accepted the possibility of causal linkages and sought to identify the antecedent or simultaneous relationships among a set of elements. In contrast, the naturalist believed that any social phenomenon was shaped by a dynamic and dialectical relationship among all elements. This precluded the possibility of naming causal linkages (Lincoln & Guba, 1985). In keeping with this principle, I did not attempt to establish any causal relationship between or among variables and the responses of Registered Nurses to job displacement.

As previously discussed, a stumbling block to embracing naturalistic inquiry was the issue of objectivity in research. In quantitative research, I saw a methodology that would gather credible data using objective means and generate statements of truth generalizable to a broader population. During the process of this study, I came to value subjectivity and view objectivity as a construction of positivism that was unachievable. Every aspect of research from the choice of a research problem to the choice of the theoretical frameworks for analysis was influenced by the social and political context in which it was undertaken. Phyllis Rose wrote "there is no neutrality. There is only greater or less awareness of one's bias" (as cited in Heilbrun, 1988, p. 30). The naturalistic paradigm assumed that inquiry was bound by the values of the researcher, the participants and the social context in which they operated. By making my biases explicit in this text, I was providing the reader with the means to judge the applicability and value of this work.

Participant Selection

One of the ways to achieve depth of meaning in naturalistic inquiry was by using purposive sampling to select participants with the most comprehensive understanding of that experience. In this case, nurses who were displaced from full-time employment best understood the event because they had lived the experience. By purposefully selecting these participants, I learned a great deal about the experience of job displacement as they felt and understood it.

Participant selection was limited to Registered Nurses and did not include Registered Practical Nurses. That was because the two categories of nurses differ in terms of the depth and breadth of their knowledge, the scope of their practice, and in their relationships to other members of the health care team (College of Nurses of Ontario, 1990). Secondly, Cameron et al. (1994) found significant similarities and differences between RNs and RPNs in their research on quality of worklife issues. Finally, research on organizational restructuring that clumped RNs with RPNs obscured changes in job redesign like the switch from one skill level to a lower skill level, and the trend toward skill mix (Dickson, 1993).

Potential participants for this study were selected from the hundreds of Registered Nurses registered with HSTAP. File selection was restricted to Registered Nurses displaced between October 1991 and October 1995 from full-time employment as a bedside nurse in a general hospital. To increase the likelihood that I would be able to contact potential participants by phone, I also restricted the search to active files (i.e., files updated within the preceding 12 months). To reduce the costs of engaging in the research for me and the participants, I chose to further limit the search to those who resided in the

905, 519, 416, and 705 area codes as bounded by the Niagara, Halton, and Hamilton-Wentworth District Health Council regions.

To protect the identity of all health care workers listed with the HSTAP database, the file search was performed by a HSTAP employee. The search yielded 38 files, 21 from the 905 area code, 1 from the 416 area code, 7 from the 705 area code, and the remaining 9 from the 519 area code. To protect the identity of potential participants, all information letters were addressed and mailed to the potential participants by an HSTAP employee. The envelopes included a covering letter from the Executive Director of HSTAP (see Appendix B), my covering letter as the principal researcher (see Appendix C), an information sheet about the study (see Appendix D), a consent form (see Appendix E), and a participant questionnaire (see Appendix F). I was provided with a list of the potential participants identified only by their first names and sorted alphabetically from A to Z. Each first name was associated with an area code and phone number.

Beginning ten days after the mailing, I made the initial contact calls. Working from the bottom of the list, I phoned each number in the 905 area code in turn until 10 individuals indicated their willingness and ability to participate in the research. Fourteen individuals were contacted to achieve a sample of 10 participants.

During the initial contact call, I introduced myself and the purpose of the study. Each potential participant verified that she had received the introductory mailing. There was an opportunity for the individual to ask for more information and clarify questions. I emphasized that a participant had to be willing to share her story and explore her responses, and able to attend three interviews and commute to a pre-arranged location for those interviews. Finally, I requested their participation in the study. If they agreed to

participate, I asked them to identify a convenient time and location to meet. Based on the geographic location they identified, participants were assigned to one of two groups.

In a second phone call, I confirmed the participants' continued interest in the study and negotiated meeting dates, times and locations for the individual interviews. I asked the participants to prepare for our first meeting by reflecting on the questions outlined on the information sheet they had received (see Appendix D).

During this phase and prior to commencing the interviews, one participant withdrew from the study. To restore my sample to ten participants, I returned to my list of 38 candidates. After placing two calls, another individual agreed to participate. To accommodate the newest participant, group membership was redistributed into three groups according to geographical location.

The ten Registered Nurses who participated in the study were women ranging in age from 20 to 59 years. While nursing is a traditionally feminine occupation, the design of this study did not exclude the possibility of men participants. All had completed a diploma program. Some graduated from schools of nursing, some from community colleges, and two were trained abroad before being licensed in Ontario. Most reported engaging in some type of post-basic training prior to their displacement (see Table 1). All were employed full-time prior to their displacement, and were practicing in a variety of settings at various general hospitals in southern Ontario (see Table 2). All were displaced at least once between February 1992 and March 1994 and two nurses were displaced twice. Their term of unemployment varied from one week to 16 months with two still unemployed after more than three years (see Figure 1). Of the eight participants who were re-employed in nursing, five had been recalled to work by their displacing employer.

Table 1

Basic and Post-Basic Training Prior to Displacement

	Basic Nursing Training			Post-Basic Training		
Participant	Hospital Based	College Diploma	Outside Canada	Non-credit Courses	College Credit	University Credit
1	x			x		
2[a]			x		x	
3			x	x	x	
4		x		x	x	
5	x			x	x	
6	x					
7	x					
8		x		x	x	
9		x		x	x	x
10		x		x	x	

[a] The participant did not complete the written questionnaire. These data were drawn from the information provided by the participant during the individual interview and may be incomplete.

Table 2

Pre-Displacement Employment by Practice Setting and Type of Hospital

Participant	Practice Setting	Type of Hospital
1	long-term care	community
2[a]	operating room	community
3	general surgery	teaching
4	long-term care	community
5	neonatal intensive care	community
6	adult intensive care	community
7	long-term care	community
8	adult intensive care	community
9	neonatal intensive care	community
10	neonatal intensive care	community

[a] The participant did not complete the written questionnaire. These data were drawn from the information provided by the participant during the individual interview.

Figure 1. Participants' employment history in nursing from October 1991 to October 1995.

While most preferred to return to full-time employment, only one nurse had found a temporary full-time position. A few had more than one employer (see Table 3). Most were underemployed with several earning less money working in jobs requiring more skill or training (see Table 4). These data were drawn primarily from the questionnaire and provide an overview of the participant group. A detailed picture of the findings is presented in chapter four.

Data Collection, Recording and Analysis

Data collection was a three-step process (see Figure 2). In the first step, data were collected using a questionnaire and through individual interview. In the second and third steps, data were collected through group interviews. Data analysis was also a three-step process and entailed: (1) identifying themes and patterns; (2) naming patterns and contradictions in meaning making; and (3) comparing findings to other data sets and theoretical frameworks (see Figure 2). The focus of data collection in each step was informed by the analysis of findings collected in the previous step.

In the first step of data collection, I met with each participant individually at the pre-arranged time and location. I reviewed the purpose and format of the study and clarified any questions she had about the study (see Appendix G). All candidates signed the consent form retaining a copy for themselves. Then I collected the completed questionnaires.

The four-page questionnaire provided introductory data about the nurses' displacement, training and retraining, and labour and economic adjustment. Nine participants submitted completed questionnaires. One participant who had discarded her

Table 3

Current Employment Status by Practice Setting and Hours of Work

Participant	Hospital Employers			Community Agency	Self-Employed
	#1	#2	#3		
1	Part-time			Part-time	
2[a]	Part-time				
3					Casual in nursing
4				Part-time	
5				Casual	
6	Full-time				
7[b]					
8	Part-time	Part-time	Part-time		
9	Casual			Casual	
10	Part-time				Part-time non-nursing

[a] The participant did not complete the written questionnaire. These data were drawn from the information provided by the participant during the individual interview.

[b] The participant is unemployed.

Table 4

Current Employment Status in Nursing Compared with Pre-Displacement Status

	Same Employer in Nursing			New Employer in Nursing		
	Same or Similar Job	Different job		Similar Job	Different Job	
Participant		Less skill	More skill or training		Less skill	More skill or training
1	x			x		
2				x[a]		
3					x[b]	
4					x	
5						x
6			x			
7[c]						
8	x			x		
9	x					x
10	x					x

[a] The participant did not complete the written questionnaire. These data were drawn from the information provided by the participant during the individual interview.

[b] This participant was self-employed as a private duty nurse and had not defined the scope of the job.

[c] This participant was not gainfully employed in nursing at the time of the study.

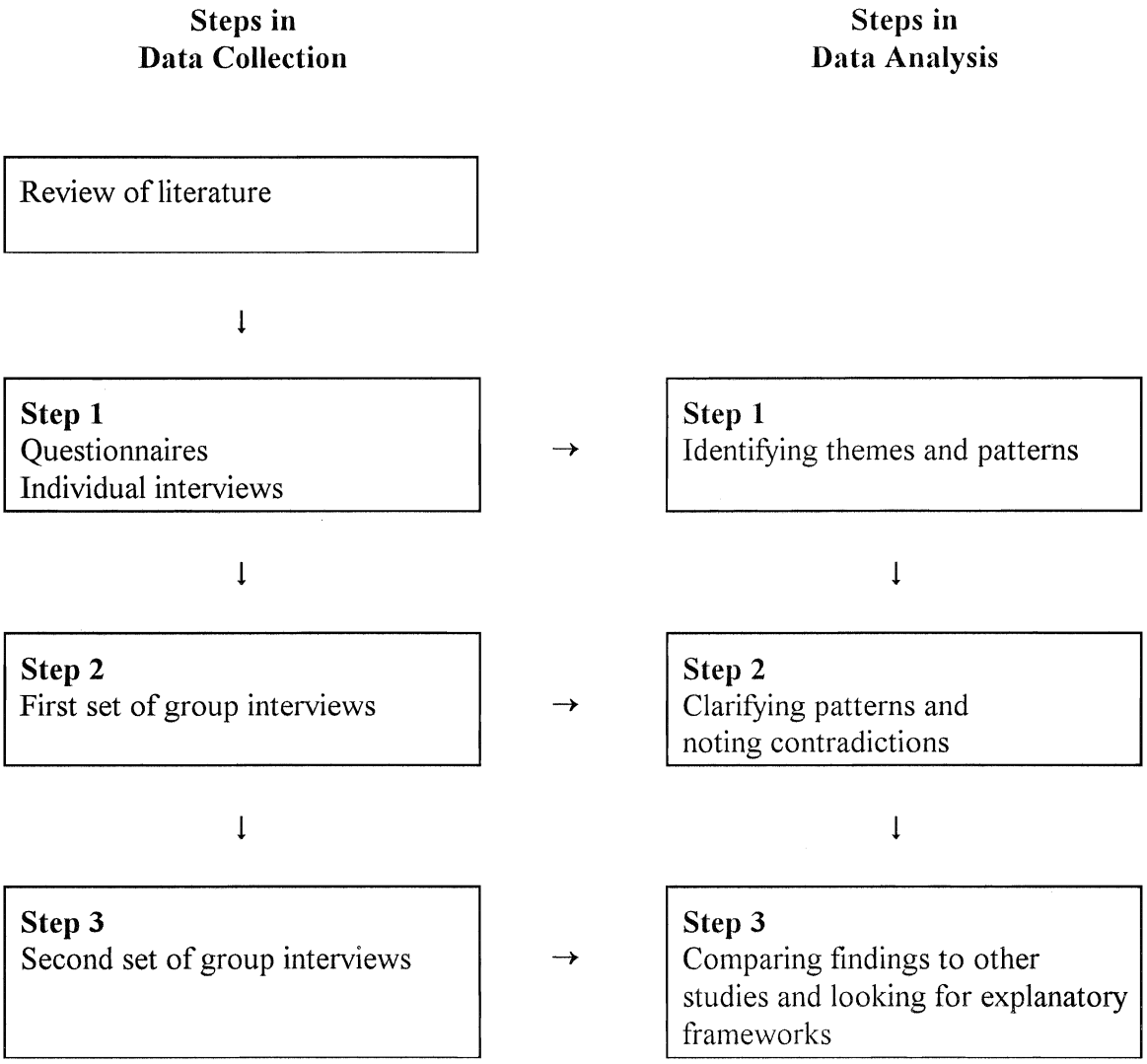

Figure 2. Process of data collection and analysis.

questionnaire prior to agreeing to participate in the study was provided with another at the time of the first interview. Later she withdrew from the study without submitting a completed questionnaire.

At the outset of individual and group interviews, I stressed the confidential nature of the interview material, and asked participants to respect the confidences shared by other group members both in the form of transcripts and group discussion. During this first conversation with each participant, we talked about her displacement from full-time hospital employment as a staff nurse. The questioning guide for the personal interview (see Appendix G) was used in collecting introductory data about the physical, emotional, and social context of their displacement experiences. The semi-structured format permitted each participant to raise the issues that seemed relevant to her at the time.

On occasion I recognized a need or opportunity to share information about resources. Some participants expressed a sense of isolation, and a lack of knowledge about resources and support. Initially I felt it inappropriate to provide information in my role as researcher. I concluded that the conflict represented a pull to assume the neutral stance of researcher that was consistent with the positivist paradigm (Reinharz, 1992). Thereafter, the conversations became an exchange of ideas and information between researcher and participants for the educative benefit of all (Lather, 1991).

As my first conversation with the participant ended, I discussed the next phase of the study. Each participant identified convenient dates and times for the first group session and provided a mailing address for written communication.

Conversations lasted 50 to 70 minutes and were tape-recorded and later transcribed into text. The pages and lines of text were numbered for easier reference by

me and the participants. All data were coded with no use of their previous or present employing agencies. All interview data were identified with only the participant's first name, and the date and time of the interview. All other details that could identify individuals or employers were removed prior to distribution to participants. All computer files were password protected on diskette and stored with all original audiotapes in a locked filing cabinet in my home study. All material will be kept for five years and then destroyed. Each participant retained a copy of her own interview transcript.

A copy of the interview transcript was mailed to the individual participant accompanied by a covering letter (see Appendix H) and a self-addressed, self-stamped envelope. Offering participants an opportunity to read and edit the transcript of their personal interview served three purposes. As previously mentioned, transcript review constituted a means of member checking or validating findings. Reading their transcript also prepared participants for the group interview by encouraging a reflective activity. Finally, asking participants to review their transcript also reinforced a sense of ownership for the data and allowed each participant a chance to edit or delete any data she did not wish to share with other participants or include in the study.

Each participant was asked to call or mail editing changes, or to confirm she was prepared to share the transcript in its original form. If participants did not respond by a pre-established date, I contacted them by phone to discuss their decision.

A revised copy of the personal interview transcript was mailed or FAXed (if time were limited) to the other members of the participants' groups. All copies of transcripts were returned to me for disposal by the end of the study. Reading the edited interview transcripts of other members of her small group was a mechanism for: (1) reducing the

amount of group time devoted to "ice-breaking" activities; (2) giving as well as receiving validation and support of their personal story prior to meeting other participants in person; and (3) reflecting on the themes in their individual and collective stories. Instructions were provided in the covering letter (see Appendix I). The letter included a set of questions for discussion at the first group interview. The questions reflected the themes I noted while transcribing the interviews into text.

It was at this point that three participants elected to withdraw from the study. All identified family or time conflicts or both. Sadly, all three, who were re-employed at the time, also identified pressures relating to impending downsizing at their current employer. Two of the three were facing their third possible displacement! All three offered articulate information about their displacement experiences and I was pleased they agreed to let me include their questionnaires and the edited versions of their transcripts in this study. I did not share their transcripts with other members of their respective groups.

Preliminary data analysis occurred after each interview as I found myself submerged in the transcription process. I jotted down common descriptions and responses, language, ideas, and concepts as I recognized them. Then I read each edited interview transcript to restore a sense of the wholeness of the interview. After about four or five interviews, I identified five recurrent story lines: emotional responses to displacement; action responses to displacement; training and retraining; being a nurse; nursing as a profession; and nursing labour. In reviewing each transcript for a third time, I marked significant statements related to each theme. Later, I extracted these statements from the transcripts grouping the quotes under each of the five tentative categories. Based on this preliminary analysis, I formulated the question guide for the first group

interview (see Appendix J).

In the second step of data collection, I continued with the remaining seven participants meeting with them in groups of three and four. Group conversations added richness and detail that comes with sharing a common experience with others while allowing participants to give and get support from cohorts. This outcome addressed my ethical concern about the potential of causing emotional distress when participants recalled unpleasant memories, or evaluated themselves or their responses critically.

These conversations which lasted about 2 to 2½ hours were audio-taped and later transcribed into text. Participants clarified and explored their personal stories and searched for patterns in their collective stories. I verified that themes I identified during the first step of analysis were a valid reflection of the participants' displacement experiences as they felt and understood them.

With the data gathered during the first group interviews, I followed the same procedural steps for analysis. I found some ambiguity and overlapping among the categories I identified in the first step of data analysis. Although I tried to more clearly define these categories and reassign some data, I was not satisfied at that point with the groupings. Based on my analysis of the data collected, I generated another question guide for the second group interviews (see Appendix K).

Again, participants had the opportunity to review the transcript of their first group interview. As before, the transcripts were mailed or FAXed to the participants together with the covering letter (see Appendix L) that included a questioning guide to stimulate and guide reflection.

The second set of group interviews lasted 75 to 90 minutes and followed the

format and questioning guide (see Appendix K). I asked participants to review the themes and assist me in making sense of these findings. Including participants in this way respected their ability and right to be "producers of knowledge" (Reinharz, 1992, p. 17). Participants commented on the patterns and contradictions I noted and worked with me in generating possible explanations. We focused on articulating, analyzing and theorizing about the social, political and economic forces that shaped their displacement experience. It was also during this second group meeting that we addressed issues of closure for the participants and the researcher.

During the third step of data analysis, I reviewed the last set of interview transcripts searching for common themes and patterns in the ways these nurses made meaning of their displacement experience. Using the research questions as a guide, I adjusted the groupings to reflect the understandings and meaning making generated by the participants.

These groupings were reorganized again after returning to the literature for further analysis of the data. Comparing my findings to those of others, I searched for concepts that would help me interpret the findings. Chapter four presents the findings and my interpretations.

CHAPTER FOUR: FINDINGS

Introduction and Overview of the Chapter

The purpose of this study was to identify and explore the responses of Registered Nurses to job displacement. This chapter presents the research findings collected from the individual and group conversations. Demographic data provided in chapter three presented a snapshot of the participant group. In this chapter, colour and texture are added to this picture with the varied accounts nurses gave of their displacement experience. These findings are organized thematically under the broader headings of the three research questions. How nurses responded to job displacement reflected steps in a three-step process of labour adjustment and reconstruing their social reality. This change process is discussed in the context of the literature. This chapter concludes with a brief summary of the research findings.

Responses to Displacement

The participants in this study had a variety of responses to job displacement. The stories they told were poignant and compelling. They detailed their shock and disbelief, their embarrassment and self-doubt, and the bitterness and resentment they felt when they were displaced from their jobs. Above all else, these women were angry. The first subsection is devoted to a presentation of these findings on being angry. Two other responses to job displacement, the search for a new job and the effort to retrain, are presented in the second subsection.

On Being Angry

Expressions of anger were powerful and pervasive in the stories told by the displaced nurses in this study. "Anger is the one word I can use throughout the whole thing... . I am still very angry at everyone... . I mean from management to fellow employees to union. They all are part of that anger." (Conversation B, Feb. 15, 1996). These participants talked about their anger with the provincial government, the union and their union leaders, and other co-workers. Most notably, nurses were angry with hospital management. Emerging from the data were three issues which fuelled their anger with hospital management: (1) being excluded from the process of decision making; (2) being treated in uncaring and insensitive ways; and (3) being the primary target of staffing cuts.

Most participants were angry about being excluded from the process of decision making. "Everything was a big secret," said one nurse of the weeks prior to her official layoff notice. Most recalled a tense and uncertain work environment in the months prior to their notice of layoff. As this nurse said, "When you're anticipating something like that to happen, you hear all kinds of rumours. Everybody's talking; everybody's trying to figure out what's happening." Privy only to rumours or misinformation prior to their displacement, one participant denounced management for "the lies and the deception" that were part of the restructuring process. This story was typical:

> I think it was in '93 that we started to hear rumours about Bob Rae's fund cutting... . In July, they called a group of us down to the Human Resources office and they said, "Don't worry. Everything is okay. You're not going to lose your job." Then about six weeks later, they called us back down to the office and they said, "You're going to be laid off." Ten of us got laid off from intensive care! And

they just said, "There's been a change of plans, and you're not needed anymore."

Asking participants about these and similar statements, and the repeated use of the word "rumours" in their stories confirmed that these nurses were left out of formal discussions regarding downsizing and strategic planning. Being excluded was disheartening for those who wanted to participate. As bedside nurses, they were involved in direct caregiving activities and were, therefore, knowledgeable about patient care and staffing needs. They were not even included in these decisions. Instead, "the decisions are being made by people who have never worked in the department." As one nurse explained, it was not unusual for nurses to be excluded from all levels of decision making in hospitals:

> Nurses were not, and are not, part of any decision making in any area of the hospital. When it comes to new equipment, you're not part of the decision making but you use the equipment. We're just totally out of the loop. I would magnify that beyond just this case about restructuring.

The second issue these women discussed was the insensitive and uncaring ways layoffs were carried out. One nurse who was off work on Workers' Compensation said, "I felt like it was a firing." She recalled receiving her official notice in the mail:

> The last date of working was effective on that date that I received it, funnily enough. It was as simple as that and as heartbreaking as that... . It was total disbelief. Absolute disbelief. I actually looked at the envelope twice to make sure it really was mine... . I had to check my name and address to make absolutely sure that it really was for me... . I was astounded.

Another participant described in poignant detail how her unit manager avoided facing her

on her last day at work:

> She never said, "Good bye," "Good luck," "Catch you later." Nothing. Not a word. And that was kind of cruddy. It was maybe awkward for her. I don't know but I don't care. We're getting laid off, and you're a unit manager. And I think you should have said, "Best of luck." I don't know. Something. But she didn't. We felt not supported. It was hard. It was very hard.

A few were angry about the way the restructuring process was communicated to the public through the media. One nurse described how her employer misrepresented the nature of her layoff to the other employees and the local community. She recalled, "They [management] don't consider me laid off; they consider me retired. I got invited to a retirement party and everything because they say they don't have people there that were laid off. They don't lay off anybody. That really got my back up." She recalled how the local newspaper published the management version of her job loss: "They had a picture of all the 'retirees' at this retirement tea. And they put 'absent' and my name. So I wasn't long in ringing up the newspaper and saying, 'No. No. This is not right. I did not retire'." There was, however, no retraction, apology, or effort on the part of the newspaper to investigate her version of the story. In another case, a participant and her colleagues wrote letters to the editor of their city newspaper protesting the layoffs of dozens of Registered Nurses. She explained why the public would only read the management version of downsizing: "The head of the [name of city newspaper] was on the Board of Directors at the [name of hospital]. So there was no way that any of this was ever printed in the paper."

Even after their displacement, managers continued to behave in uncaring and

insensitive ways toward displaced nurses. One participant who had been displaced from the neonatal intensive care unit was recalled to work a single shift to help move equipment into the newly renovated unit where she would never again work. Another participant who had been displaced from her first full-time job felt angry when management insinuated her unemployed status was of her own making. She recalled meeting with the human resources administrator to determine her eligibility for recall to a part-time position:

> I'm still resentful, actually... . Basically her attitude was that it was my own fault. That this was a fine mess I'd got myself into because I wasn't qualified for any other floors to work on in their hospital. And my attitude was that it was them that laid me off and put me in this situation in the first place.

These displaced nurses were also angry with managers who feigned concern and interest in their well-being. After being recalled to work for a few months, one nurse recalled being notified that she was being laid off permanently:

> We get a phone call from one of the managers, a Human Resources manager, very sweet, very understanding. And she's offering us a really good buy-out package, only to find out that they have to offer it to us. It's how she presents it. I come away thinking I'm being manipulated here.

Because of the unfair way the process of decision making evolved, some confronted their administrators. One Registered Nurse recalled her futile attempt to get satisfactory answers: "You would assume that when it would happen it would happen orderly, and it would be fairly done. The answers would be there and you would say, 'Well, I understand. You had no other choice'. But it didn't happen like that." Another described protesting the layoff decisions:

> There was a large group of us laid off, and we went down, and we argued and screamed and carried on. There's nothing anyone can do. And the ones who are left behind are thankful to have a job therefore they accept what's given to them because they have a job.

Sometimes, confrontations with management had dire consequences. One nurse described how a colleague had written a letter to the Board of Directors of her displacing employer "to make them aware of some of the things that were going on." She recalled that management publicly denounced this action as harassment, and instructed the employee that she was not, under any circumstances, to initiate any further contact with the board. A similar story was told about another nurse who was forbidden to come on hospital grounds with threat of legal action if she did not comply:

> She was very upset like everybody else was upset that got laid off but she ran with it. She went to the union first and she did what she could there. And then she went to the newspaper, and she went to a labour lawyer, and on and on. And she didn't keep it quiet what she was doing. And it got to the point where she was told not to step on hospital grounds. And she wasn't doing anything other than trying to fight for what she thought wasn't fair.

While some expressed their anger directly to management, others did not. Although one nurse needed and wanted answers from her displacing employer, she did not try to approach them. She struggled to explain this to herself:

> Nurses didn't verbalize very much. I certainly didn't... . I didn't have any fight. I was just so woeful. I couldn't. I couldn't feel at the time what to do... . What can you do about it? That's the way they handle it. If you want to have input, they

> don't want to hear it. It's a waste of energy to even try to put your point across. So, what can you do? You're just a little mouse there. That's the way they operate so you just have to accept it no matter how you feel about it.

The third issue that fuelled nurses' anger was the way RNs, as a group, were targeted for layoff. This point had several facets: (a) other cost-saving mechanisms were not as widely used or investigated as staffing cuts; (b) other hospital workers, especially administrators were largely unaffected by layoffs; (c) management used their position to manipulate the process to their advantage; and (d) patient care suffered as a direct consequence of nurses' displacement.

It was difficult for these nurses to accept that management would choose to target RNs instead of implementing other cost-saving strategies. As one said, "I was just so hurt because there were other ways they could have compensated rather than deleting staff... . But they didn't choose the other ways." Most agreed that, "they [management] could have looked a little bit more deeply into things, and they could have cut back in a lot of other areas." Several concluded that cutting nurses was more expedient for management than trying to search for other ways to cut waste. One nurse imagined a budget meeting might have gone this way:

> If the nurses' salary per year is this much, if we chop, chop, chop a hundred of these people, look at this big saving. It's enormous! It's wonderful! Why should we go looking for a penny here and a penny there and a penny everywhere else? It's quick. It's efficient.

Several noted the disproportionate number of RNs displaced from their hospitals while other hospital workers were largely unaffected. Most pointed to the top-heavy

bureaucracy, and the way management protected their own jobs. As one said,

> They have put a building out the back which is not very visible to the public, full of offices. You see the strangest titled offices all down the one hall... . They were not affected... . Management was not affected by the layoff even though they claim they were. RNs were the only ones affected, heavily affected by the layoff. And I'm very angry about that.

Nurses held administrators responsible for cost overruns and the budget deficit. They cited examples of poor management practices and poor long-range planning. One nurse pointed to recent programs that sponsored nurses from abroad to meet an apparent nursing shortage in Ontario hospitals in the late 1980s. Another questioned why her displacing employer had hired several Registered Nurses, including herself, within months of announcing their displacement. Expressing the view of several nurses, one said:

> Basically I believe that management was really not held accountable for their decision making. And then, at the end of the day, the people who got us there, are the ones who have to make the decisions on how to get out of the debt. And they're not the ones that are penalized. They're the ones that are still sitting there in their jobs. And they cut the nurses.

Just as managers protected their own job, these RNs believed that managers used their position to manipulate the process to their advantage. Several nurses were angry that management's decision to layoff staff (instead of using other cost-saving strategies) forced the implementation of the seniority rule laid out in the collective bargaining agreement. They held that the seniority rule valued only the duration of employment and did not value the nurse as a whole person. Several contended the seniority clause unfairly

protected senior nurses who were "not doing their job, abusing the sick time" while failing to protect the jobs of less senior nurses with higher education or demonstrated competence and versatility . One participant told how she and her colleagues in ICU protested management's decision to retain more senior, uncertified nurses while displacing highly credentialed nurses "who could take any patient that walks in that door." Management responded to their complaints by arranging to train those nurses who lacked certification. She claimed it was an empty gesture "to make it look good" as some nurses refused training and continued to hold their jobs. She held the nurse manager accountable for failing to protect patient care and the jobs of more qualified Registered Nurses.

Participants talked about the ways contractual agreements between management and union were enforced and relaxed at the discretion of administrators. A nurse who had worked for several years in a neonatal intensive care unit told how she was bumped by a nurse with more seniority and "no qualifications" to perform her role. She contended this was contrary to the contract, and that management had relaxed the bumping rule to serve their own purpose. Later, when she applied to fill an opening in the adult intensive care unit, she was turned down. Although she believed that her knowledge and skills were transferable, she was told she didn't have "all the courses" to qualify. When she challenged management to explain why the rules had changed, she received condolences but "no answers to those kinds of questions." Unable to get reasonable answers to a reasonable question, she concluded, "They flip-flop all the time. When it benefits them, suddenly it's a rule. And then when it doesn't, they switch it." Upon hearing this story, another nurse commented, "Its almost like you feel even more screwed. Because, I mean, the rules within the same contract are different for different areas."

There was yet another way that these nurses described being deceived and manipulated by administrators. Management had told them that nursing positions were being eliminated. These nurses argued that the hours of work were simply redistributed among a different group of workers. One RN explained, "People that were on casual, that for years had hardly been working at all, suddenly were getting full-time hours and I was sitting at home." Another participant told a similar story: "Our work was absorbed by the regular part-time nurses who are now working full-time hours. And by them posting four more permanent part-time positions a year after we were laid off, the hours are still there. They were just given to other people." Nurses who worked for community agencies were also being brought in to cover shifts. Most participants were quick to clarify it was not individual nurses who angered them. "I don't blame those nurses. I mean they have to look for work. But again, I think it's poor management because they [agency nurses] cost so much more than having their own staff." Most concluded that management were displacing full-time Registered Nurses to save the dollars paid out in employee benefits.

As these women shared their stories and their anger toward management, they tried to make sense of their job displacement. Most participants talked about the need to reduce the deficit. One nurse drew an analogy between the hospital budget and her family budget saying, "I have a budget at home. I know I have to live within the means of that budget. I would not go out and recklessly spend because I would know that the basic necessities would have to be cut somewhere along the line." Although she saw nurses as a basic necessity, cutting staff positions was a way to compensate for gross overspending in the hospital. Still she was not entirely satisfied with this explanation. She continued, "I could see how, coming from an accountant's point of view that looks like the best way to

do it. But having gone through it and suffered it... well, of course, because I'm a nurse, I'm going to say, well, I don't agree with it."

Several nurses made a connection between their job displacement and their pay increase resulting from pay equity legislation. One said, "They [RNs] got a good raise but they deserved that raise. Yes. They're worth it. Expensive is not the right word but they were a big part of the budget, and that's why they were targeted. They're a large body. But they [management] didn't look at that - just the bottom line figures." Another nurse added the element of visibility to her explanation. She explained it this way: "It almost seems like they target you because they think you're making the big dollars (which isn't true in all cases). And because you're the front-line person out there working."

Using the element of visibility to explain nurses' displacements generated some interesting discussion. While most believed visibility was a factor in deciding what to cut and what to keep, they did not think this worked in favour of nurses. On one hand, nurses were seen as the visible health care providers, the front-line workers in a hospital setting. But as the largest group of workers, their wage constituted the biggest part of the budget. This visibility made nurses an easy target. Another participant used the same ideas to explain displacement differently. She and other participants were outraged to learn that their layoffs coincided with management's decision to allocate health care dollars to new medical technologies or hospital renovations. Renovations were highly visible and an attractive physical environment was desirable. She said, "Management felt with improved surroundings, they felt more appealing to the outside possibly. They're looking for support from the community." Nurses' work, on the other hand, was generally unappreciated by the general community "unless they are ill." This made nurses less

visible and more vulnerable to displacement.

Another participant added the element of political power to the equation linking job displacement with wages. She explained it this way:

> I'm questioning power. Nurses, in the last probably ten years, have become much stronger. They're questioning doctors. They're questioning a lot of things. I really have to wonder whether or not they [management] like that. I think that's part. The other thing is cost. RNs are expensive in comparison to RPNs... . The other thing is they're visible. Management is not visible to the public.

Despite the failings of management, at least one participant felt very strongly that managers played a vital role in a hospital organization. "You must have someone in control of the department... . You need a head to get organized. You must have a head there. You must! At all times. Regardless of what she's doing and what she's not doing." Others disagreed and wanted more autonomy and control over their day-to-day labour. This point will be discussed further in the third section in this chapter.

To summarize the complaints against management, nurses were angry about being excluded from the process of decision making, angry that job displacements rather than other cost-cutting measures were viewed as the mechanism of choice. That RNs were targeted while others, including management, were not affected was especially upsetting. The participants were angry and hurt that layoffs were implemented in an uncaring and insensitive manner, and angry that they were lied to and manipulated before, during and after the process. Finally, nurses were angry that administrators were not held accountable for the mismanagement of health care dollars.

Participants in this study also levelled criticism against the provincial government.

Some were angry that the government had not intervened earlier. With long-range planning a common organizational practice, they speculated that government bureaucrats "must have seen this coming." One nurse who had worked for a large metropolitan teaching hospital recalled,

> They were $69 million in debt but every year, they have been bailed out, and bailed out. And the debt kept growing greater and greater. They had to take some responsibility and basically the government said, "We don't have the funds. We don't have the finances to keep bailing you out. This is your budget. You have to work within it." And this is the first time that this has ever happened.

Some were upset that the government was not more involved in the reform process at the local level. Some felt that with more government involvement, their jobs may have been saved. As one explained,

> When they dictated the hospitals should cut, they should have dictated that a percentage had to be cut across the board from every area in the hospital. That decision should not have been left up to management because as it was management was not touched.

Others did not think government bureaucrats were any more likely to make good decisions than their hospital counterparts. Several stories suggested these women felt the provincial government had shown poor judgement with managing their own budget. One nurse spoke about the way the provincial government tried to reduce its own deficit by reducing transfer payments to hospitals. This in turn applied additional pressure on hospitals to reduce their spending. By off loading their problem onto hospitals, that government action ultimately resulted in her displacement. She concluded, "You know, it

was all political." Another nurse commented on the way the government allocated monies to other provincial projects at about the time she had received her layoff notice. She recalled, "I was really ticked. I'm getting laid off and they're putting up these road signs that you don't even need." Outraged, she contacted her local MPP and "voiced my opinion to the powers that be" and later, followed up with a letter restating her point of view. A few doubted that government strategies to reform health care would realize any savings. Drawing an analogy between the social contract and cost-cutting strategies in health care reform, one nurse said, "Now, apparently the numbers are out, and it didn't save one penny."

Despite their negative reviews of the process itself, there was a general acceptance among participants about the need to cut spending and waste in health care. Said one RN, "I really feel that the whole health care system has been taken advantage of for a number of years." Others agreed. With opinions informed by the media and their own observations, one remarked, "The newspapers, the news and, I mean, the writing was on the wall. From my point of view and from others, we saw the waste. We see the waste. We know that things can be streamlined."

These participants also supported the strategic directions proposed by government. They discussed the advantages of moving from treatment of disease to disease prevention and health promotion, from patient care services delivered in hospitals to community based programs, and from a physician-centred to a client-centred and family-oriented approach to health care delivery.

The participants in this study also talked about their anger with the union and the union leaders. All but one of the participants had worked in unionized hospitals and were

members of the Ontario Nurses' Association at the time of their displacement. The union was their collective voice in all matters with management.

Most participants sought help from their unions immediately after receiving news of their layoff. Many approached the union leaders for guidance regarding the range of choices available to them while on a recall list. Most reported that they had to manage without the support they needed and to which they were entitled. One nurse recalled, "We filed grievances after grievances only to find out later on that we signed all these grievances and half of them weren't even filed. We were called into a grievance meeting and it was such a joke." To further illustrate the ineptitude of her union, she told this story:

> The union did nothing. The union did absolutely nothing. Except about six months later, six months to a year later, [the union] passed another ruling that all on-call hours will go to the permanent part-time before they go to the on-call staff which eliminated us again.

The union seemed powerless to help these nurses. One nurse observed, "Management is pulling out rules from all over the place. They don't care. They know they can get away with it. And the union, for some reason, still hasn't got it together to have clear cut rules written, and be able to go in there and say, 'Knock it off'." When one participant asked union leaders why the collective bargaining agreement had no layoff language, they had answered that "they just weren't prepared for any of this." This astounded her and she remarked, "That just never would have happened in any of those other unions."

The data in this study were collected at a time when the Ontario Public Service

Employees Union (OPSEU) was embroiled in a noisy strike protesting government cuts to staff and service. While OPSEU had garnered public support for their cause, ONA had been unable to create the same level of publicity and public sympathy for their cause. The irony was not lost on these women as they tried to understand why the general public did not seem to react to the plight of nurses displaced by health care reform. "If you don't know someone who is a nurse or you don't have someone who is sick in the hospital or you don't have some reason to be directly affected by this, I'm not so sure that you'd give it a lot of time because it doesn't impact you as much." This, in part, explained to some why their union was unable to stir more public support.

Some participants expressed anger toward their colleagues who failed to acknowledge the impact of the layoffs on those who were displaced. As one nurse said, "They did not call. They did care what I was doing. They say they do when you see them but really it was an eye-opener. Like no support from that side." It was not uncommon for nurses to receive their layoff notice weeks before their last working day. This meant nurses who were being displaced continued to work with nurses who were retaining their jobs. One nurse recalled that "they weren't comfortable with talking about the layoffs with us. They all reacted very differently but they found it best, almost, you got the feeling, not to talk about it."

While it was difficult to deal with some co-workers' silence, others found it equally difficult coping with the remarks of others. Several told stories about co-workers who often seemed unsympathetic or too self-involved with their own well-being to be supportive of those who had received their displacement notices. Many times these displaced nurses had to listen to their colleagues openly verbalize their concern for their

own job security. Insensitivity took another form as this story suggests:

> When they listed the ten of us that were going to get laid off, I remember I was working. And they were going down the list deciding, out loud, who they should feel bad for... . They'd say, "Her husband just got laid off but she's got no kids", or "Her husband has a good job so that'll be okay," or "She's single so she'll be fine. She can go wherever." And they went through every single one of our names. And I thought, "Who are you people to decide who is going to be okay, and who you should be upset for?"

Sadly, a few participants turned the anger in on themselves. One nurse felt angry that she allowed herself to feel secure in her job, and had not foreseen her own displacement.

> I didn't even feel anger immediately. I felt anger later when I tried for many, many jobs... . I think if I had been more observant. I guess I felt very placid and very sure that I would always have a job in nursing. I had never once, ever, thought the possibility of not nursing was something I should be looking at. Never. Not even though everything was going on around me, I was thinking it wouldn't affect me.

As these nurses sat together, sharing their stories and talking about their anger, it became clear that several were at different points in resolving their anger. At least one nurse denied being angry any longer. She explained, "I'm not angry. It takes so much energy to be so angry. And at the last gate, it's a waste of energy." Another suggested being re-employed was a significant turning point for her in dealing with her anger and her job displacement. She posited, "When you get a different job and you get absorbed in it, it gives you closure to that situation. And although you don't understand it [being displaced]

maybe I'm not as angry now because I'm happy in what I'm doing. And that makes a difference." Reflecting on her own situation , another nurse answered her this way, "I haven't found another work avenue that I've found where I can let go of the past and move on... . You had the job to help you get through it. I didn't have the job. That's the problem, you see." Two nurses were still very angry, and one of these nurses had no plans to ever let go of her anger.

> I've gone on with my life. It's not all consuming. It's not something I think about day after day... . When the subject comes up, I realize how angry I am. And that will never go away because I think it was done very unfairly... . We were left out in the cold by everybody. By management. By hospitals. By unions. There was nobody... . And that part is what I'm angry about. And that will never go away because they can't undo what they did.

With these words, this nurse summarized the anger all these participants had felt, and named those they held accountable for the pain of their experience.

On Searching for a Job and the Effort to Retrain

Faced with unemployment and underemployment, most participants in this study initiated job search and retraining activities. Their experiences, and how they understood them are presented in this section. These participants described several ways of valuing training and retraining, and the connection between training and employment. Emerging from the data was the understanding that they, as nurses, valued training and its connection to work differently from management.

Most nurses in this study were placed on a recall list at the time of their layoff.

Although one was recalled almost immediately, most waited weeks or months before being offered work by their displacing employer. Even then, most returned to casual or part-time rather than full-time positions. A few were never recalled to work and sought work in other settings.

Looking for work was a difficult activity for a couple of reasons. Prior to organizational restructuring, these nurses had not needed or developed job search skills. Jobs had seemed easier to find and secure. It had been twelve years since one participant had searched for work. She compared that experience to her recent attempts to find a job saying, "You don't just walk in and say, 'Here's my resume', they ask you a couple of questions, and the job is yours if you want it. That's what happened with the other jobs I had. Now that doesn't work anymore. You're drilled... . And just about everything. I wasn't prepared for that." Attending workshops on resume writing, networking, and being interviewed helped them develop specific job search strategies many felt they lacked.

Looking for work was also difficult because of the fierce competition for the limited number of nursing jobs available. It was these women's experience that prospective employers could choose from among the most experienced, skilled and educated applicants. Thus a strong educational background seemed to be a basic prerequisite for re-employment. Those who were re-employed linked their educational history and willingness to continue upgrading with their success in finding work. But as others in this group found, being well educated was no guarantee of becoming re-employed.

The participants in this study noted that even nurses who had never been displaced were taking upgrading. One nurse laughed as she explained, "Everybody is taking courses

thinking it's going to save their jobs... . You wonder the value of the courses. Whether people are really taking them because they want to or they're just taking them because they're forced to." The message from management seemed clear. As one put it, "Its just constant - education, education. And even our manager said, 'The best thing you can do is stay educated. Educate. Educate. Educate'." While demanding a certain level of preparation when hiring staff, they did not value it when determining which staff were retained. "The expectations of what they want for us are greater. And yet they don't really seem to really recognize that when it comes to layoff... but we are still expected to do all these skills". So, although the nurses in this study who were re-employed were sceptical that being well trained was any safeguard against being displaced again, they continued to take courses.

These courses which met the demands of the employer for continuing education could be said to have management value. These may or may not have been courses which the nurses perceived as helping them better perform their jobs. As one said, "The expectations of what the management wants you to maintain as a nurse are still very high. They want you to keep all your certifications, your CPR." One re-employed nurse with extensive experience in maternal and child care resented administration's demand that she and her colleagues enrol in a two-day breastfeeding seminar. As she put it, "We've taught breastfeeding for how long? Now we have to have this certificate."

All but one participant attended some kind of training following their job displacement, and four were enroled in courses at the time of the research (see Table 5) Engaging in training after displacement reflected these nurses' commitment to learning and skill development. Prior to their job displacement, all participants reported attending

Table 6

Nursing Retraining and Non-Nursing Training after Displacement

	Nursing Retraining			Non-Nursing Training		
Participant	Non-Credit	College Credit	University Credit	Non-Credit	College Credit	University Credit
1	x					
2[a]						
3				x	x	
4		x		x		
5		x		x		
6				x	x	
7		x		x		
8		x				x
9	x	x		x		
10	x	x		x	x	

[a] The participant did not complete the written questionnaire but indicated during the individual interview that she had not undertaken any form of training since her displacement.

hospital inservices or professional workshops and seminars, and several completed specialty certificate programs offered at local colleges. As one put it, "Its just that I wanted to be the best that I could, and I can't work without knowing what I'm doing. So that's why I did those things." Although many had experienced difficulties in attending appropriate training prior to their displacement, these nurses continued to seek retraining following their job displacement.

Seeking training was also a way to fill the time, and deal with the impotence and inactivity of unemployment and underemployment. One nurse recalled, "I was climbing the walls. And I had dozens and dozens of resumes out everywhere, and nobody was hiring because everyone was cutting back... . So there was a lot of frustration at that time, and I ended up taking some courses." The process of engaging in training activities helped these women deal with the sadness, anger, frustration and self-doubt that were part of the job search. Three enroled in courses with other colleagues who were also displaced at the same time. They enjoyed the collegial support and used the time they spent together as a forum for discussing their responses to job displacement.

Extended terms of unemployment and underemployment caused many to question if they would be able to maintain their skill and knowledge in nursing. One nurse who was recalled was seldom scheduled to work in her area of specialty while other more senior nurses with less knowledge and experience worked in her place. She described approaching the nurse educator saying, "If I don't soon get down there one of these shifts, then I've already told the pediatrician, 'Don't ask me for help because I forget how to do it'."

These displaced nurses needed and wanted continuing education or an opportunity

to practice and maintain their skills. Consequently, many participants chose to take courses in nursing after their job displacement. Community nursing courses, the choice of several participants, reflected their belief that they were preparing for the shift toward community-based health care delivery. One recalled thinking, "That seems to be where the trend is out in the community. There won't be a problem getting a job." Training was valued, therefore, for its potential for developing or enhancing specific competencies. This may be called content value. In general, however, courses such as those in the community nursing certificate program were viewed by these nurses as lacking content value. Most who had taken the training did not believe the courses prepared them to perform a new or more specialized role in the community. In fact, only two participants who enroled in community nursing courses found work with community nursing agencies, and both held casual positions. Neither of these two believed the course content was relevant or useful in their new role. Instead they found that on-the-job training in the community more rewarding and applicable than the college courses they had taken.

Fearing job opportunities were limited in nursing, several attended career counselling workshops believing they would get help defining a new career path. Based on this counselling, two enroled in year-long retraining programs. While both had been optimistic that they would find work, neither found employment in their newly chosen field. Both felt their time and money had purchased false hopes instead of job opportunities.

Being successful in an avocational endeavour was especially helpful to one woman whose identity was shattered by extended unemployment. She spoke with pride about learning to play the violin although she "couldn't read a note of music." With avocational

training, she named the challenge, overcame the obstacle and reaffirmed her image of herself as a capable and successful person.

As the period of unemployment or underemployment stretched into weeks and months, these women became increasingly frustrated and discouraged. To secure a job and an income, many accepted part-time work. Some were simply grateful to have a job while a few described their new jobs as rewarding. One RN who had accepted work outside her area of expertise said, "Its opened new doors for me... . into research and stuff like that which I have never done before." Weighing the lower wage "which is an issue for everybody" against preferred hours of work, higher morale and better working environment, she was enjoying improved physical and mental health. For this nurse, as for some others, the work they were doing demanded more skill and training than their pre-displacement work. For at least one who had accepted work in a doctor's office, the work required less skill or training. In both cases, nurses often earned less money than prior to their job displacement.

These nurses explored the reasons for their unemployment and underemployment during individual, and later in group, sessions. In individual conversations, participants tended to explain their employment status in terms of their age, employment history, education and other personal attributes. One explained her inability to find full-time work this way: "No one was hiring new grads especially because you didn't have enough experience." Another participant brought her resume to our first meeting as if to prove she was qualified, capable and deserving of re-employment. Another who was perplexed by her fruitless search for a job in nursing, recalled her self-talk between interviews:

How can I best sell myself? What is it I'm doing or not doing? Why am I not

getting these jobs? I'm called for the interview, so the resume is okay. What happens at that interview? And I always wanted them to tell me. And, of course, they won't discuss that. So, there's no way you can not do that the next time.

During group discussions, these participants challenged each other to identify other factors external to themselves to explain their difficulty finding employment. When one participant pointed out that her age was the most likely reason she was not re-employed, another nurse said, "It didn't matter what age you were, whether you were younger or whether you were older. The frustration was there because there were no jobs out there regardless of our ages." This lead them to discuss why they had been displaced initially. Many were left wondering why management did not value their education, skill and experience as they did. As one nurse put it, "I went to school for a long time... . Because they have to put more money into educating you, maybe they won't get rid of you so easy [sic]. That's kind of what I thought which, of course, was a big fallacy in the end."

In telling their stories, these nurses differentiated among the ways of valuing training and retraining, and the connection between training and employment. A training program was valued for its content or its potential for developing or enhancing specific competencies or restoring a sense of a capable self. These nurses differentiated between this kind of training which they believed enabled them to better perform their job, and that which management required of them to keep their job. A training program was also valued for its chances of getting an applicant a job interview and or increasing one's marketability. Resume value or the impact of a list of recent training experiences indicated to a prospective employer that a nurse was able and willing to learn. This value was not equated with a guarantee of employment in the same way that basic training once

guaranteed employment in nursing. These participants recognized that the supply of highly credentialed and experienced RNs far surpassed the number of available positions. Finally, nurses talked about training in terms of its retention value. This was the degree to which training was believed to help a nurse retain her job. Although nurses generally believed that specific training was necessary to practice in any given setting, they believed that additional training or certification were not valued enough by management to be used as a criterion for retaining well-trained staff.

On Professional Identity and Being a Nurse

When the participants in this study talked about being a nurse, they spoke about their relatedness to their work and to patients, to the nursing profession, to their employers, and to money. Emerging from the data were ways that job displacement affected these connections and in turn their professional identity.

As the participants spoke about being a nurse, they talked about how their professional identity was connected to their work and to their patients. Most entered nursing believing they would always have work because there would always be people who were ill and needing nursing care. One participant expressed it this way, "I love working. I love what I do. I look forward to going to work. I've been in nursing since I was 17. And, you know, it was the only thing, basically, that I ever wanted to do." Another nurse spoke about her decision to become a nurse: "Its the cliche of nursing. 'Why did you go into nursing?' 'Oh, I like to help people'. That was my thing with nursing. It satisfied a need to help people." Being a nurse was central to how they defined themselves. As one said, "a lot of my identity was tied up with being a nurse."

Being displaced was a traumatic life event which affected how they felt about themselves as nurses. One described it this way: "Its like taking the foundation stones out of the house and then, the whole house just falling down." Some felt disconnected from the clients for whom they cared. As one nurse said, "You knew that you served a purpose in that capacity. And then when you lost that, you lost some purpose. You liked being around the people that were there and all of a sudden you were alone." Another said, "I guess you could say I lost more than just a job because I really got into helping people. It was more of a part of my self."

Many participants missed being able to render care as they had in their role as a bedside nurse. For a few, this need to care was met by involving themselves in other caring work. When paid work was not available, volunteer work was one response to displacement. One described canvassing for charity, and advocating for the elderly by serving on a community action committee. Another, displaced from a long-term care unit, talked about volunteering at a retirement home.

> I didn't actually have my finger in the pot but I was in and around... . I was still around older people and helping them out doing whatever. By helping the volunteer activity person, and keeping busy, that way it kept me around other people... . and still sort of had me in a helping area which I think it's important to do that.

Not only did they miss the connection to their clients they also missed feeling connected to their work and to other nurses. As this nurse remarked, "A lot of my socialization takes place at work and I was missing that. I was missing a big part of my life."

A long period of unemployment made their disconnectedness to work and clients more noticeable. One woman began to doubt her knowledge and skill to practice nursing. She said, "I think, gradually, you lose a lot of confidence in yourself... . I mean, can you still do it, you know? You know you're not as sharp as you were, you know." Reflecting on the years of unemployment since her displacement she said ruefully, "Right now I don't feel like a nurse."

Facing unemployment meant imagining a future without nursing. One said, "Yes, it's satisfying but there are no jobs out there. And at this stage of the game, if I had to do it over again, I wouldn't be a nurse." Although one participant engaged in career counselling hoping to discover a new career path, she found it ironic being told that "nursing was kind of my thing." Another admitted, "I don't know anything else. And I don't even know what else I would consider."

Another way in which their professional identity was affected by job displacement was in the connection with other nurses as a group. Some feared reform initiatives marked the beginning of the end of a category of Registered Nurses. While they acknowledged their own and other individual acts of protest, they agreed that collective action was essential. Said one nurse, "Everybody was fighting singly... . And there's no power in being the single person coming forward." Most agreed that nurses who retained hospital employment also lacked power to effect change. One nurse recalled discussions with her previous colleagues this way: "Everybody that works there feels like a prisoner. They feel like, 'We [management] own you and you can't do any better'. Things like, 'You can't get out. You can't get another job'."

Neither the Registered Nurses' Association of Ontario nor ONA had been visible

and effective forces in advocating for their rights during the reform process. One group talked about the differences between their union's response to health care reforms and those of CUPE, OPSEU and physician groups. Some blamed the profession for not better protecting the scope of nurses' labour. One said, "I think we're our own worst enemy a lot." Another agreed, "Look at the physicians how they all lobby together when something makes them mad. Now not very often are nurses all together out there lobbying for some issue or trying to make a point about their profession. We're not as vocal, I don't think". One woman explained the lack of solidarity among nurses this way:

> We are the largest group in the hospital and we are not solid with each other. Nurses are very fickle people in regards to standing tall for an issue. We're getting better. I think, on the whole, most nurses will back down. They would rather back down than say, "I stand for this".

Another participant offered a different insight:

> How do we have time to be so diligent in our fight to make our union? We have a huge union but we're not a strong union at all... . I mean we don't have time. We're exhausted. How can we find time for one more issue to put on our plate? And I wonder if they [management] take advantage of that a bit?

Later she said of devoting time and energy to union activity, "Its not our priority. If you get a choice of what's your priority, your job, your husband, your family, your kids, it won't usually be your job."

With great hesitation some participants discussed the power differential between men and women at work as a way of explaining to themselves nurses' level of participation in the reform process and their position in the health care system. One observed that

nurses were less vocal "because we're women." A few attributed nurses' responses to women's dislike for conflict. "We'd rather get along. Afraid we're going to get into trouble". Another suggested that "[men] were out there in the work force ahead of us" working together, and creating the rules. Several believed that nurses had a different way of thinking about things than men in business. One nurse who had been enroled in an management course recalled an instructor chiding the class to "stop thinking like nurses." The message she received was that thinking like a nurse was not a good thing. She went on to say, "Business has a totally different thought when it comes to health care, and we're not trained that way. We expect everyone to be caring and nurturing like we are, and that's not the reality of it now."

A nurse's connectedness to her employer also seemed to affect how she felt about being a nurse. One nurse's comment reflected the feelings of many who were "very disillusioned, not with the patients, but with the things that surround it - with management - but not with actual nursing. I still feel strongly about that." While they were angry with management for the many reasons we discussed earlier, they expressed feelings of confusion mingled with regret. Many felt they had been good and loyal employees. As this nurse said, "If you do your job, you should be rewarded by continuing to have your job." Being displaced caused one woman to question the years she had devoted to an unappreciative employer instead of to her growing family. "I was always frustrated and always stressed out, and I really didn't enjoy the kids... . I had missed a lot because I had worked full-time for nineteen years." One nurse questioned aloud the inequity of that employee-employer relationship she had valued:

Who wants to give their whole heart, soul and everything else to someone who

> says, "We don't want you"? I'm glad I'm not there. If they don't have respect enough to deal with this terrible situation a little bit better, a little more compassionate, then why do I want to go back there again and get slapped at some other date, maybe?

In reevaluating her connection with her employer, another nurse said of her job displacement, "I feel relieved and lucky. I do. It forced me to get on with my life. The layoffs has been good in a lot of ways. It's forced me to realize I can live without [name of hospital], thank you!"

Finally, the participants talked about their professional identity and how it related to money or financial reward. For some being displaced meant lost dreams for annual vacations, for an early retirement and, for one, the loss of a much anticipated extended maternity leave with her newborn son. For those who were single or single parents, the financial consequences were more significant. For two participants, being displaced spelled serious financial hardship. One nurse wondered aloud if "they look at us as secondary breadwinners - like most of us have husbands who are the chief breadwinner, and our income is supplemental," or as another said, "a day out of the house." Being displaced sent them the message that they and their work were dispensable. This was contradictory to the way they valued themselves and the centrality of nursing in their lives.

Although a number of participants mentioned financial concerns, this was not the main way in which they talked about their connection to money. In fact, it was often the contrary as this women said, "They took something away of my self rather than just a pay cheque." Another compared money to other rewards she was losing, "I was losing my pay cheque from the hospital... . But it was the whole other part that seemed harder to deal

with - not having patient contact . That whole part that was wiped out. That was a big part of who we are." A nurse in her 50s explained the relationship between nursing and money this way: "At this stage of the game, you want to be there [at work]. It isn't when you're younger, when you're out there because you need the money and so on. Well, I still need the money but I really enjoy my job."

A nurse's connectedness to her work and her patient was not driven by money and could not be given a dollar value. Stories about unpaid overtime hours illustrated the way some participants viewed themselves and their work. One explained, "I'd stay that half hour. I don't want to get paid for that half hour. That was between me and that patient.. . The money wasn't important. That was not why I was in nursing, ever." For this nurse and a few others, there was no way of equating caring with money and to do so devalued the caring and the connection.

Still, for many the connection between money and nursing was pivotal in explaining to themselves why they were displaced. When pay equity legislation resulted in a substantial pay increase, some participants hailed it as long overdue recognition for valuable work. They equated being underpaid for nursing with being undervalued. As one put it,

> I never felt that we were given credit for what we did. Financially or any other way... . The hours we put in. The shifts we do. I never felt we got paid for it adequately. And once our salaries did go up, that's when all this displacement started. Anybody who goes into nursing now I have to question why.

In telling their stories they drew connections between the undervaluing of their work in hospitals and their work in the home. Said one nurse of domestic labour, "We're

living in the wrong society to have value placed on that!." Another explained the undervaluing of women's work this way, "I think it's historical. I don't think that society sees that as an important role. I don't think that's seen as important as the man who is out there [in the public sphere]." Implicit in this statement was the valuing of men's labour over women's work. They also talked about the value of technical labour. Using the example of the patient classification system, one participant illustrated how technical aspects of their labour were valued and caring aspects of their work was not. "You get a mark for assessment. You get a mark for giving your medication. You get a mark for your dressing. There's no place where it says how many marks you get for your nurturing or your hand-holding or your family support."

In summary, being displaced affected the connections these nurses had to their work and to patients, to the nursing profession, to their employers, and to money. The disruptions in these connections affected their professional identity and how they felt about being a nurse.

On Changes in the Nature and Utilization of Nursing Labour

In telling her displacement story, one nurse shared her vision of the future role of the Registered Nurse. She imagined that most Registered Nurses of the future would be concentrated in managerial roles, and that direct patient care would be provided by RPNs, aides and generic workers. Registered Nurses who wanted to provide direct patient care would be limited to highly specialized and technical hospital settings like ICU. Patients and families would be more involved in care, and everyone would have greater access to health care services in the community. This vision reflected many of the significant

changes these nurses observed in their nature and utilization of their labour.

The nurses in this study felt that RNs were being squeezed out of direct patient care activities and expected to perform more clerical and supervisory activities. When they were employed, they had been expected to devote more time to documenting the planning and implementation of patient care activities leaving them less time for patient care. Most participants preferred hands-on nursing and resisted this change. As one nurse said, "I know they're trying to get the RN into a manager type of position. When I was there at the end, it was 'Stay at the desk.' I don't know what's going on if I'm sitting at the desk. I want to be out there." Although these bedside nurses believed that nurse-patient interaction was an important part of nursing, most talked about nursing labour in terms of completing tasks rather than providing patient care.

Nurses in this study had felt constantly under pressure to complete all kinds of clerical and technical skills. To keep up with the emphasis on medical technology they were focusing on becoming technically skilled. Prior to their displacement, most nurses had been expected to learn new skills such as inserting intravenous devices. Following her displacement, one participant found her prospective employers had similar expectations. She recalled, "They don't want you to have just nursing skills. They want you to have computer skills. They want you to be bilingual, and this and that." While some attributed their re-employment to having a wide range of technical skills, they admitted they were applying those new skills in new settings, and earning less money. Some, like those who had worked in the operating room and the intensive care unit, enjoyed the challenge of highly technical jobs. A few liked adding new skills to their repertoire believing that that enabled them to provide more holistic care. Still others felt it had less to do with better

patient care and more to do with management's expectation that they perform more tasks during their shift.

Nurses also felt pushed into assuming all the jobs that were left undone by other health care professionals and hospital workers. Instead of devoting time to providing nursing care, they found themselves engaged in non-nursing functions such as loading laundry hampers, running messages and checking meal trays. As one nurse explained her dilemma: "We don't have time. I mean, if the staff isn't there, then if you're going to do the nursing care, you can't be doing housekeeping chores, and dietary chores and all the other."

In addition to these changes in the nature of nursing labour, staffing cuts meant there were fewer RNs sharing a heavier work load. Cutbacks mean that staffing patterns were seldom adequate for the number and acuity of patients. As one nurse put it, "Now, there never is that luxury. So, you just manage." They thought it obvious that caring for sicker clients demanded more nursing care not less. Many participants observed, however, that "they're not getting it. You do what you absolutely have to and have the time to do. But there are some people you never see at the end of the shift. And that's not fair." When asked to make sense of management's decision to cut staff, one nurse explained it this way:

> It's [nurses' work is] appreciated by the patients, and the patients' families. But I don't think it's appreciated by the hospital itself. The business aspect of the hospital and the management aspect of the hospital, I don't think that they appreciate nurses and the quality that nurses are worth. They just look at the dollar value and think instead of two nurses doing whatever on a shift, we can get

> away with one nurse on this shift. And it doesn't really matter if patient care suffers.

Although RNs were being displaced, most participants noted that RPNs and generic workers were taking their jobs and performing their functions. This heightened tensions between RNs and RPNs, and between full-time and part-time staff. One participant described a typical scenario:

> RPNs were hired at the time RNs were laid off. The hours were still there when we were laid off. They went to the girls who worked permanent part-time. They went to full-time hours all of a sudden. Girls were doing overtime hours. And yet, there were six of us out of that department. But the hours were there.

One nurse explained management's decision this way: "They [management] just look at the dollars and figures. And if they can have an RPN who has the experience of giving meds or IV push drugs or what not, they would rather replace with that nurse [RPN] rather than an RN because they cost less."

There was considerable discussion about how other health care professionals, especially RPNs, were eroding the role of the RN. As one nurse put it, "I almost feel like they're choking us out." As RPNs began to perform elements of their labour, these nurses felt the clear boundaries of the RN role were fading. One nurse wondered aloud what would be left of the RN category: "They're [RPNs are] being trained for jobs that used to be only RN jobs. I can really see the RN category being almost eliminated. You really have to begin to wonder about that. They can do almost what we can do." Several participants expressed concern that RPN training was not sufficient to replace the RNs' level of knowledge and expertise. As she explained,

> The RPN's role is starting to increase an awful lot. And I think too much so... . The assessment skills that they are supposed to have, they don't have. Their role has almost become equal to what ours is and I think it's very dangerous. But I don't blame the individual RPN. I blame management for allowing that to happen.

When asked to make sense of their job displacement and the use of other caregivers, one said, "I just think there is no sense to be made of it. None. But I do believe it's a political thing... . I think it's just a political manoeuvre. And we're fall-out."

While RNs were being replaced by other categories of caregivers, layoffs also resulted in RNs being replaced by their more senior and often less experienced colleagues. As their stories indicated, layoffs resulted in a cascade of bumping in many hospitals that changed the skill level of the RN at the bedside. An operating room nurse with nine years experience was bumped out of her job by a more senior nurse who had not yet completed the basic specialty course. She said, "I know [from] working in that situation that no one after six weeks orientation could perform my job as I had." Another who had spent her career caring for the elderly was concerned when nurses bumped into long-term care. "Nobody wants to go unless they're without a job. Long-term care has always had a bit of a stigma to it. I suppose people in acute care feel that's the last place on earth they want to work. But I believe it takes a special type of caring nurse." Another participant expressed similar concerns about nurses who bumped into areas like critical care. Not only did they lack the necessary experience to provide comprehensive patient care, she foresaw the potential for "a lot of really unsafe working environments." Another agreed, "Its business now more than compassion and patient care. See those values are gone now."

These displaced nurses also told stories about how the changes in the nature and utilization of their labour were affecting the quality of patient care. Time and again they forcefully and passionately voiced their concerns that staffing cuts, heavier patient loads, higher acuity levels meant less time for individualized care. One nurse who worked with the elderly was angry about the effect of business-driven decisions on patient care:

> Most places are being run like a business now rather than a hospital... . In my type of nursing, I think that it really is hurting the whole type of care. I don't think the patients are getting the care that they should... . You can't do it... . The patients are losing dignity with every one of these items that are being dropped because we don't have the time because staff are being cut.

The emphasis on technology, performing clerical, technical and management tasks detracted from the interpersonal aspects of nursing and the sense of connectedness to client and family and other co-workers. Stories like this were common:

> You don't have the time any more. You just go and do basic care. And you have such a high work load. But you didn't really have time to put the quality into your work.... You didn't really have the time to visit that the older patient who didn't get a lot of visitors and just needed you to take a few minutes, you know, just to spend the time. And you didn't have the time to do that.

A few admitted to putting in unpaid overtime in order to provide the "little extras" they could not squeeze into their schedule of tasks.

Most agreed that reforms were negatively impacting on staff morale. While one nurse believed that she was still "trying to make the patient come first" she said, "with all the cutbacks and the hard feelings, people aren't looking at it that way, now. They're

going in and doing their job, collecting their pay, and leaving. And that kind of hurts." Another participant who was re-employed at a family practice clinic regularly dealt with nursing students who presented for their vaccinations. She sighed deeply as she said, "Part of me just wants to tell them, "Don't bother. There's no future in nursing. Why are you wasting your time and your money?'"

Several participants, however, expressed guarded optimism that their roles would undergo positive changes as the health care system became more client centred and community based. One nurse described the greater autonomy she was enjoying in her community work as compared with the increasing control of her labour in the hospital setting:

> With the hospital, especially the last couple of years, they seem to counter check, no matter what you did. They made decisions that were not in the best interest, quite often, of the patients. Because management said, "This is the way it had to be," this is the way it had to be... . So you walk away and you feel like you're being treated like a two-year old. Where I've got to say that at [name of community nursing agency], they hand you your workload and they say, "Go to your workload." And they treat you with some respect and some intelligence that you will carry out your workload properly. The other thing is that you do go in and see everybody individually which then allows you to assess whether all they need to do is talk. It's that caring part of that you're allowed to give them which the hospital is lacking now.

Many believed that the vision of moving to client centred and community based care was also in the best interest of the client. One said,

> I don't think all the changes are bad that are happening. When I see people out in the community, and they're happy to be out in the community. They'd rather be home than in hospital. They heal much faster at home than in hospital. I think that was part of the vision was to get patients back into the home.

As we discussed the future of nursing, a few commented on the way downsizing and restructuring was affecting the newest population of graduating nurses. A couple were distressed by the closure of the nursing faculty at a local community college. They feared this signalled the first of many closures to come. Another participant expressed a different opinion. She was angry and frustrated that colleges and universities continued to offer programs in nursing. She explained,

> They're coming out and there's just no job market there. And you know I think that's terrible. I really do. And then what happens is that these people, these nurses, are going south. And I don't blame them, because it's the only place they can get experience. But it's so sad that we're paying for their education to a certain extent.

Interestingly, no one expressed concern that new graduates posed competition for displaced nurses in a shrinking job market. On the contrary, younger nurses were seen as vital to the profession. "I see all the younger girls, for example, those younger than I. They are so energetic, they have so much to offer and they are not even being given a chance. They don't have a chance to start." Another lamented, "We can't nurture them. They can't get the experience. They run off to the States. What is going to happen ten years down the road?" While younger nurses were denied the benefit of working with more experienced nurses, nurses with years of experience were denied the opportunity to

provide a high quality service. Calling it a "waste of good nurses" and a "loss of potential", job displacement was viewed as a significant factor in forcing nurses to leave nursing or leave the country for want of a job or an opportunity to learn and grow in the profession .

Their stories described shifts in the way nursing care was delivered, where and by whom. They spoke about the impact of business decisions on the quality of patient care and their control over their nursing practice. They also discussed their concern for the future of nursing practice and the category of Registered Nurses. In considering all the changes in the nature and utilization of nursing labour, one nurse said, "We [RNs] were targeted, and we are being targeted. I'm wondering whether we are just working ourselves out of a job altogether."

Discussion of Findings

The purpose of this study was to add an examination of nurses' narratives to the story of hospital reform in Ontario. Job displacement was a traumatic life event that disrupted these nurses' connections to their work and their ways of understanding the world. By engaging them in conversations, they were able to tell the often painful story of their job displacement and, in so doing, they guided me through their process of reconstruing their social reality. Their various responses to job displacement reflected steps in this change process from grief and self-blame, to anger and confronting contradictions, to making choices. This section presents a discussion of these research findings as they were made understandable in the context of the literature.

Grieving and Self-Blame

Almost without exception the nurses in this study began their story by talking about the grief that was associated with the loss of their job. Grief was the first response and the first step in the process of making meaning of their experience. Being displaced was about losing a job but, more importantly, it is about losing their connectedness to their work and their identity as a nurse.

Like other displaced workers (Burman, 1988), having a job was an important part of how they presented themselves to the world. These women had been employed full-time, and job displacement changed the day-to-day reality of their lives. They grieved the loss of routine and daily structure. They missed their social interaction with co-workers and patients, and felt physically and emotionally isolated. Similar feelings of despondency and isolation were found to be common among other displaced workers who felt separated from their work and their colleagues (Burman, 1988; Davies, 1996).

The longer RNs remained unemployed, the more cause they had to grieve the fracturing of their professional identities and their world view. For a lucky few who were quickly re-employed, this period of separation and grief was brief. Many nurses in this study, however, experienced extended unemployment after their layoff. Disillusionment and discouragement were associated with protracted unsuccessful job search activities. Two nurses had bleak prospects for continuing their careers in nursing despite their diligent job search and retraining efforts. As the duration of unemployment increased so did this sense of disconnectedness and grief. As one nurse said, "The longer you're out, the tougher it gets." Burman (1988) and Davies (1996) documented similar findings among the unemployed.

The Registered Nurses in this study were not adjusting economically to layoff in terms of their current employment status, degree of continuity of working hours and ability to maintain pre-layoff wages and skill utilization. A couple of participants were permanently laid off by their employers while others returned to insecure, temporary or part-time work and a few held more than one job. Although a couple had found comparable work, most tended to work for less money in different settings requiring different sets of knowledge and skills. Grayson (1993) who investigated a far larger sample of hospital workers registered with the Hospital Training and Adjustment Panel drew a similar conclusion.

Despite these findings of poor economic adjustment, loss of income and financial stability were not a significant part of the grief the nurses in this study described. As one participant said, "I didn't find that [losing my pay cheque] the hardest part... . It was the whole other part that seemed harder to deal with, not having patient contact." This was contrary to the findings in other studies where grief and job loss were strongly related to loss of income and financial stability (Leventman, 1981; Burman, 1988). That nurses did not equate their labour with having a dollar value may reflect the historical devaluing of nursing labour (Colliere, 1986; Achterberg, 1990). Modern nursing labour had its roots in the ideologies of care and domesticity. Emotional labour (Yyelland, 1994) and domestic labour (Wilson, 1991) were provided largely by women for little or no pay and without social recognition. As nursing has not been equated with being financially rewarded, losing employment was not strongly equated with losing an income or financial security.

The key to understanding the fullness of the grief these nurses felt was appreciating that, for these women, nursing was more than just a job. In telling their stories, the

participants described their occupation as something they were meant to do, had always wanted to do, and were good at doing. Being a nurse was central to how they defined themselves. As one nurse said, "A lot of my identity was tied up with being a nurse." Most participants entered nursing believing they would always have work because there would always be sick people who needed care and because caring for the sick served an important social need. As working nurses these women had a purpose and they equated job displacement with disconnection from that greater purpose. One nurse put it this way: "You knew you served a purpose... . And when you lost that [job], you lost some purpose... . You liked being around the people that were there and all of a sudden you were alone." These ways of talking about their relatedness to nursing were reminiscent of Nightingale's conception of nursing as a calling (Achterberg, 1990). Yyelland (1994) reported similar findings in studies of nurses and their relatedness to work.

Nurses' professional identity was strongly linked to their personal identity. Images of self were intermingled with images of self as nurse. Losing their jobs meant losing an integral part of their identity or as one nurse said, losing "a part of myself." Being displaced also severed their connection with that greater purpose and they grieved that loss. The grief responses these nurses expressed were similar to those described by Carlisle (1992), Cavanaugh (1994) and Dahlstrom (1994). These nurses experienced sadness akin to the bereavement associated with the loss of a loved one (P. Smith, personal communication, Feb. 15, 1996). In this case, the loved one was the image of self as caregiver and nurse.

Just like those grieving the loss of a loved one, these nurses felt others could not understand their sadness (P. Smith, personal communication, Feb. 15, 1996). They were

especially hurt that their former colleagues did not understand the magnitude of their loss. Not only were they physically isolated from their working peers, displaced nurses felt unsupported by them. Initially, many had wanted the support of their former colleagues who retained employment but this changed over time. Working nurses seemed preoccupied with their own job uncertainty, engaged in training or jockeying for position on seniority lists. Displaced nurses were hurt and confused that their former colleagues were not empathetic or supportive. Unable to get support, displaced nurses were equally unable to be empathetic of working nurses' experience.

This aspect of their collective story supported the work of Cameron et al. (1994) who concluded that nurses as a group were vulnerable to the negative effects of downsizing. Both the nurses who were displaced and their former colleagues who retained employment were uncertain of their job future, perceived a lack of organizational support and a lack of opportunity to influence the outcome of organizational change. Displaced and employed RNs distanced themselves from each other without appreciating the ways that the political agenda driving hospital reform (Armstrong, 1995b; Lexchin, 1994) made them members of the same marginalized group.

Searching for work and engaging in retraining assuaged some feelings of grief and sadness associated with job displacement. Cohen (1994) and Zimmerman (1994) had encouraged these ways of responding positively to being laid off. Most nurses in this study invested considerable time and effort in both activities. They recalled their early confidence that they would find work quickly as securing employment in nursing had, theretofore, not been a problem for them. Most reported, however, that finding re-employment had been difficult. As Cairns et al. (1994), Carlisle (1992) and Dickson

(1993) have documented, many other qualified nurses were competing for the same few jobs. The process of looking for work was also a difficult activity because it required job search skills they had never needed or developed. Many engaged in non-credit self-help courses to improve these skills for continuing their job search efforts.

After countless interviews and rebuffs, feelings of self-doubt and self-blame began to replace feelings of grief and sadness. A few blamed themselves for their protracted underemployment pointing to personal attributes such as their age or perceived deficits in their education or employment history. In trying to understand their joblessness some reflected on the reason for their layoff. As one said, "You still get a little depressed because you feel that maybe you weren't quite good enough." These findings illustrated the way these nurses began by personalizing rather than externalizing the reasons for their layoff and unemployment. Training and experience which they had previously connected with career security and advancement had not helped them to retain or secure work. If, as they believed, occupational success were related to meritocracy, then it followed that job loss and unemployment meant they were personally responsible for their situation. For some, this resulted in expressions of self-blame and self-doubt. That these nurses felt individually deficient was not uncommon among the unemployed. Davies (1996) and Leventman (1981) reported that displaced workers often felt responsible for their job loss and personally inadequate if they were unable to find work.

Another way of looking at the grief and self-blame that was part of these women's stories was by regarding the uniqueness of the nurses' displacement experience. Their lived experience with layoff differed from the way they and the general public had defined layoff (Grayson, 1993). It was frustrating to be unemployed when, as one nurse recalled,

"That's what everybody used to tell you. There's jobs everywhere. You can get a job." A journal article, Public thinks nursing is a job for life published in Nursing Times (1992) documented the public's misinformation about nurses' ability to find re-employment after displacement. Even the Hospital Training and Adjustment Panel (1993) with whom all participants had been associated had not appreciated that layoffs in the hospital sector differed from layoffs in other sectors. The Hospital Training and Adjustment Panel was modelled after a well known and successful program, the Canadian Steel Trade and Employment Congress, developed for steelworkers (Cairns et al., 1994). While the program had been helpful in a sector where unionized workers tended to experience temporary loss of employment before returning to work, it had not been helpful in the hospital sector where workers were experiencing varying degrees of unemployment and underemployment following job displacement.

These nurses' displacement experience also differed from that of spouses and friends with whom they compared themselves. One nurse whose husband worked in the steel industry told this story:

> Health care is people and caring and non-business (or at least it used to be). And steel companies are very "Hey! You're laid off and catch you later." That's just the way it is. It's just a whole other way of thinking for sure... . When I would try to say, "I feel awful about this. This is making me so upset," and I cried a lot, he would say, "Well, buck up. We get laid off all the time." He couldn't get it. He didn't understand that this really is bothering me.

While this nurse grieved her loss of connectedness, her spouse expected her to devalue her connections and detach herself from the experience. She, like others in this study, felt

separated from yet another source of support.

Without those insights into the unique way that layoffs affected nurses in the hospital sector, these nurses, and the organization committed to their support, struggled to understand why displaced nurses, unlike other laid off workers, were not quickly finding re-employment or adjusting to their displacement. Using the same language and practices to support nurses' experience that has been used in other sectors submerged the impact of job displacement on nurses.

Being unable to find full-time employment gave these nurses time, cause and opportunity to question their displacement and continued unemployment. Gradually, grief and self-blame turned to anger as they confronted some contradictions in their ways of understanding the world. Recalling a change in her way of making meaning of her experience, one nurse said, "I was more angry at the people in control of making these decisions and blaming it on me, rather than me blaming it on me." As these participants shared their stories and their anger, they took me to the next step in reconstruing their reality.

Berger's (1963) discussion of circles of social control was helpful in explaining this process. The nurse was located, metaphorically speaking, at the centre of a set of concentric circles. These circles represented a variety of implicit and explicit social forces. The inner circles of control were those forces which operated in interpersonal relations while the outer circles of control were those political, economic and social forces which operated in the larger context. During this first step in the process, displaced nurses' ways of making meaning of their experience focused on those elements over which they believed they had control and which influenced their experience most directly. They

pointed to personal attributes to explain their displacement and their unemployment. When they compared themselves with others in similar circumstances, some found themselves lacking or personally deficient or confused about why they had been displaced. As their view expanded beyond themselves and their inner circle of relations, they considered other social forces impacting on their experience. Extended unemployment triggered anger, further questioning and exploration of larger circles of social control.

Getting Angry and Confronting Contradictions

As time passed, these nurses' ways of construing the world no longer helped them understand the new reality they were experiencing. In their stories they talked about their anger and their struggle to reconcile the contradictions between their old beliefs and their new context. Recognizing contradictions was the second step in the change process.

The displaced nurses in this study accepted the assumptions underlying the need for reform. They had heard government and corporate claims of overspending, cost overruns and systemic inefficiencies like those published in government documents (OMOH, 1992; OMOH, 1993; OMOH, 1994c; Working Group on Health Care Services Utilization, 1994), discussed in nursing journals (O'Brien-Pallas, 1992) and the media. They, like many social scientists in North America (Glazer, 1993), accepted these claims as "truths." They agreed with the assumptions that Canadians were overspending on health care, that cost cutting was necessary to preserve medicare and that organizational restructuring was necessary to use resources more equitably. Displaced nurses, like the nursing academics (Baumann et al., 1995; Cameron et al., 1994) and unions leaders (O'Neill, personal communication, July 5, 1995) supported calls for cost containment and

the rationalization of services. As one nurse put it, "I can understand the system wanting to cut back. If this is the only way that they can meet their budget, this is what has to be done." Because they accepted these assumptions underlying the need for reform, they focused their attention and anger on the reform process, and how it evolved.

Several participants accepted that eliminating jobs was a reasonable way of reducing expenses because wages constituted the largest part of the hospital budget. All had expected staffing cuts would be fairly implemented across all occupational groups. Instead, they found that nurses suffered an unfair share of the staff cuts while other groups, like management, were spared. This outcome made them question their belief in fairness and due democratic process. Instead of applying the same rules to themselves, nurses saw administrators who controlled the reform process protect themselves and their jobs. As administrators were responsible for balancing the budget, these nurses expected that administrators would be held primarily accountable for the mismanagement of health care dollars. Campbell (1987) and Yyelland (1994) documented that bedside nurses worked in an environment that rewarded and punished nurses according to their job performance. This should have meant that managers would have experienced significant layoffs but they did not.

When trying to understand why they had been targeted, these nurses directed most of their anger at nurse managers and hospital administrators whom they perceived as having the most direct influence in the restructuring process and their displacement. During the first set of individual conversations, some participants were careful to say that they could only speak for themselves and their own experience of being treated badly by management. After sharing their stories and recognizing that their experience was shared

by others, one nurse commented, "Everybody got treated the same way even though everybody came from different hospitals... . It's like everyone had the same management, just a different hospital."

Management's control of the decision making also affected which RNs were displaced, who was bumped, and who was recalled to work. These participants had believed in the union contract and the ability of their union leaders to protect their rights throughout the layoff process. Instead, they found layoffs, bumping and recalls to work were applied unfairly and inconsistently among nursing staff. When they voiced their concerns, management asked them to believe that they and their union leaders had "misinterpreted the language of the contract." Administration seemed to have the power to make and change the rules to suit their needs while their unions seemed powerless to prevent this from happening. Their belief in contractual agreements and fair play were called into question by their lived experience.

Several nurses also struggled to reconcile management's espoused commitment to patient care and their decision to layoff caregivers. These RNs believed the purpose of a hospital was to provide quality patient care. They had shared management's commitment to the efficient use of human and material resources. Still, they questioned the cost to patients and patient care that resulted from widespread cuts of nursing staff. One nurse asked, "What are they basing their decisions on? How can they justify letting the caregivers go when they've got to realize that patient care is going to suffer?" They believed quality patient care entailed balancing both the technical and emotional components of care. This belief reflected the College of Nurses' (1990) definition of nursing practice as well as the findings of other studies (Cameron et al., 1994; Yyelland,

1994).

Displaced nurses also questioned the high costs of advanced technologies when care, concern and compassion were often regarded as more important by their patients. This finding was well documented by Armstrong et al. (1994) and OCHU/CUPE (1995). Nurses especially resented losing their jobs at the same time health care dollars were allocated to upgrade medical technologies and renovate the existing physical plant. In their experience, the increasing emphasis on technology in nursing practice and the business emphasis on efficiency did not translate into improvements in patient care. Armstrong and Armstrong (1994a) and Glazer (1993) reported similar findings. As one nurse observed, "There are a lot of other things that could be dealt with. But it seems that everybody just focuses on that nurse." This comment was typical of the stories about nursing jobs that were targeted while other cost-saving mechanisms were unexplored. These women's lived experience coincided with Campbell's (1987) observation that nurses historically have been required "to absorb a disproportionately heavy burden of cost containment" (p. 463).

One way of understanding the targeting of nurses was to consider nurses' roots in the ideologies of motherhood and domesticity. Wilson (1991) argued that household efficiency has been regarded as women's/mothers' responsibility. To improve household efficiency women have had to increase the intensity of their labour and absorb the greatest burden of ownership for the work. If this practice were true in the household, it may have transferred to the hospital. One may argue nurses were expected to carry the burden of labour intensification and cost containment because hospital efficiency like household efficiency, was also assumed to be women's (nurses') responsibility.

The experience of these women also suggested the number of patient care hours was not declining but was just being redistributed among a different group of workers. They noted the switch from full-time to part-time employees that has been documented by Duffy and Pupo (1992), Glazer (1993) and Hiscott (1994). They believed their recall to part-time work rather than to full-time positions reduced costs associated with pension and other employee benefits, a finding that has been documented by Hiscott (1994).

They also noted the switch from RNs to RPNs and generic workers that has been discussed by Armstrong et al. (1994), Armstrong (1995b) and Glazer (1993). While these nurses acknowledged that the shift toward a less expensive caregiver made good business sense, they questioned the ability of RPNs to perform their role with the same degree of expertise. That they were being replaced by less skilled and educated workers sent them the message that bedside nurses were like interchangeable parts. As one RN observed with chagrin, "I think they're [management are] saying they can train these RPNs ... and pay them less, and get the same value out to them." Rather than a less skilled caregiver, these nurses believed that the higher acuity levels demanded a better trained caregiver. Yet, with each new round of layoffs, RNs were eliminated and replaced by RPNs or generic workers. Their experience, which has been supported by Angus (1995), Glazer (1993), and Yyelland (1995), indicated work transfer and "deskilling" resulted in less time for appropriate and adequate patient care delivery. These nurses concluded that substituting cost effective forms of labour was not justified if the vision of better quality care were not realized.

One way these nurses understood labour reorganization was as a way of reinforcing the subordinate position of nurses both as a group and as individuals. Said

one, "It seems that nurses are always a target. They always earn too much. They always are expendable. It's the nurses who have to go." These nurses' stories also indicated that, following downsizing, individual employees had less power in the workplace regarding the labour process, scheduling and so on. As one nurse said of nurses working for her former employer, "Everybody that works there feels like a prisoner. They feel like, 'We [management] own you and you can't do any better.' Things like, 'We've got our thumb on you,' and, 'You can't get out. You can't get another job'." Hiscott (1994) documented that part-time workers had less political clout than full-time workers.

These nurses were angered by the incongruities between the proposed benefits of reform and the outcomes they experienced. These nurses had envisioned that reform would result in a more holistic, client-centred approach to health care delivery and a shift from hospital-based to community-based services. Returning primary responsibility for the care of the sick to the home and family was, in the opinion of these nurses, of medical and moral benefit to the family. The ideologies of self-directed care and client autonomy have been promoted in their nursing education and hospital mission statements (Wizowski, 1994), and by their professional associations (Gregor, 1995) and the government (OMOH, 1993; OMOH, 1994b). Their experience, however, suggested that patients received a poorer quality care both in hospital and in the community. Hospital restructuring which entailed, in part, shorter patient stays, early discharge programs, and higher patient turnover (OCHU/CUPE, 1995; Working Group on Health Care Services Utilization, 1994) resulted in higher acuity levels and insufficient time to provide anything more than basic care to patients in hospital. One nurse commented, "Patients who are coming out of hospitals are disillusioned with hospitals. There's (sic) not many that have good

experiences anymore. They're are just glad to get home, no matter how sick they are. They're just glad to be out of hospital." Some participants who were re-employed in the community found that because of the push for early discharge there were "more problems at home." Clients often required more complex management than what was not readily available in the community. Their observations were supported by OCHU/CUPE (1995) who claimed that the necessary infrastructure for community services was not yet in place. These nurses struggled to reconcile their support for cost containment, privatization of care and the promise of holistic client-centred care with the elimination of nursing positions, the emphasis on technology and poorer quality patient care and services. As Gregor (1995) pointed out, the alignment between the government agenda and nurses' holistic approach to health care was an illusion.

They were angry that management could, and had, exercised the power to exclude them from participating in the decision making process. One nurse tried to explain to herself how the relationship between nursing and management had evolved:

> It's nursing. Always, with every person you meet, every person you care for, you always listen attentively, and you always meet their needs. And I think we don't switch off from a caregiver to when management comes in, or some authority figure comes in. You try to understand their point of view. They're saying this because this is their expertise. They say it has to be done and we don't know what goes on behind those office walls... . They don't give us options usually. They say, "This is the way we're going." So again, you say, "Okay."

This comment supported Yyelland's (1994) contention that it has been nurses' responsibility to regulate emotion and maintain workplace harmony. This occupationally

driven responsibility constrained some nurses in this study from advocating for themselves. The language of this story also resonated with the ideologies of care and femininity that have been central to nursing practice and limited nurses to a subordinate position in the system.

Although these RNs perceived themselves as team players concerned about quality patient care and fiscal responsibility, they were excluded from sharing in team decisions. The contradiction between their valuing of themselves and management's valuing of them was best illustrated when one nurse said, "They perceive me as a small cog in the big wheel. I don't perceive myself as small." The lack of nursing input into strategic planning sent them the message that nurses were not valued members of the health care team. Their experience replicated that of other hospital nurses in Ontario (Baumann et al., 1995) whose participation in hospital reform was non-existent, or limited and meaningless. Despite the government commitment to encourage partnerships at all levels of decision making (OMOH, 1992), there was no mechanism in place at the local level to ensure that these nurses were heard. The failure of both local and provincial officials to include nurses in meaningful ways in strategic planning reproduced the subordinate organizational and social position of nurses and women in health care.

Being excluded from decision making and subsequently displaced caused them to struggle with their image of themselves as professionals. Their nursing education (Wizowski, 1994), professional associations (College of Nurses, 1990; Ontario Nurses' Association, n.d.) and nursing academics (Cameron, et al., 1994; Gregor, 1995) had represented nurses as professional members of the health care team. Some displaced nurses suggested that their layoffs were connected to the wage increase associated with

pay equity. As one said, "I have a hard time believing that these things just seem to happen. I really believe that somewhere on paper that this is exactly what was planned." Yet when describing their experience, they talked about being excluded on many occasions from organizational decision making, having little or no control over their day-to-day nursing practice, and little or no control over the outcome of strategic planning. This was more consistent with a subordinate position in the organization as described by Campbell (1987), Wotherspoon (1994) and Yyelland (1994). This left them confused about their image of self as professional when they compared it with the image reflected back to them by others.

Finally, these women questioned their affiliation with people and a system that had been so uncaring in the way they laid off staff. If they, as nurses, could use care in their work, why could not those in management reflect some care of the whole person? As one RN said, "I wanted them to say, 'This wasn't easy for us'." These nurses felt as if they had been employed by an impersonal institution that was rejecting care and embracing the business ideology. As one nurse tried to explain to herself, "They just do the statistics. And it's just on paper. So they don't follow up. Well why should they? Goodness gracious! They can't get into that, I suppose. But it would have been nice." Similar findings came from studies of the reorganization of work processes in the Canadian (Cameron et al., 1994) and American health care system (Glazer, 1993).

They struggled with the contradiction in the way they understood the term <u>care</u> and the way it was used by managers to abuse them and their emotional labour. They pointed to the irony of terms like <u>health *care* system</u>, <u>patient centred *care*</u> and <u>primary *care*givers</u> when nurturing and caring were ignored as essential components in patient,

healing and welfare. Their contribution of technical skill provided in a caring manner was devalued by the system. As one nurse said, "I don't think the management ever realized how much some nurses give." They questioned why they, whose labour symbolized the *caring* of hospitals, did not merit caring treatment.

The stories of these nurses illustrated how they expressed their anger by fighting back in different ways against an unfair system and unfair and uncaring treatment. Initially, they put faith in their union leaders and the collective bargaining agreement and negotiated through union channels. These findings supported studies indicating that Canadian women have been increasingly visible in union activity (Wilson, 1991), and nursing unions in North America have become increasingly militant (Glazer, 1993; Yyelland, 1994). The participants in this study also approached their management demanding answers. Some sought outside legal advise. A few wrote letters to local newspapers while a couple met with, or wrote a letter to, their local members of parliament. These actions reflected displaced nurses' belief in due process and political fairness and the conviction that their legitimate concerns would be heard.

It was not long before these nurses found their concerns were trivialized and depoliticized. What one nurse knew as fiction came to represent her history when a newspaper rescripted her displacement story as a retirement. Despite her letters and phone calls she found she was powerless to change the details of the story. Whether a factual or fictionalized version of a woman's life, the published retirement story came to represent her displacement event (Heilbrun, 1988).

Another example of political resistance was one participant's refusal to bump another less senior nurse. When displaced the first time, she exercised her right to bump

saying, "At the time, I thought it was a good idea." That experience changed her feelings about bumping. Displaced a second time, she was faced with choosing between two unacceptable options: bumping another nurse out of work or refusing to bump and losing her own employment. She concluded, "It just causes so much hard feelings. I just made up my mind that I'm not going to do it anymore." Refusing to bump meant refusing to participate in an unacceptable institutional practice. In choosing to be unemployed she was also choosing to retain her moral integrity and deny institutional power to dictate her responses. This issue of choice will be discussed again.

One way of understanding nurses' limited political control was to regard the association of nursing with women's interactional and caring work in the home. Nursing has historically been associated with women and women's domestic work (Colliere, 1986; Cohen, 1994). Nurses' work has been devalued because the skills and knowledge associated with nursing have been considered innate/natural. On several occasions these nurses described caring labour as "the little extras" or as a "luxury" rather than an integral part of their work. In so doing they reproduced the devaluing of their own labour. Transferring the work of an RN to the other category of nurse reflected the systemic undervaluing of the special knowledge and skills required of both categories of nurses and the expectation that both categories would work harder for less money.

Again, Berger's metaphor of circles of social control was useful in interpreting the dynamics of this process. As these nurses searched to reconcile the contradictions between their old beliefs and their new reality, they expanded their view beyond themselves to question other elements of control. They focused most of their attention on the relationships with their employer and their union. They were angry with management

for abusing them and their labour. They were angry with their local union for failing to protect them, their jobs, their professional autonomy and the scope of their labour. A few looked beyond these circles of social control to explore the role of government, pay equity legislation, their professional organizations. With great hesitation a few broached the issue of gender and work. As the discussion expanded to these outermost circles of control, the relationship between their experience and political, economic and social forces became less tangible and more difficult to examine. Another part of their hesitation to explore these issues may have been related to the methodology which had encouraged exploring common ways of understanding their experience. Because these conversations were, for some participants, one of the first forums where they felt their displacement experience was validated, they may have hesitated to explore those avenues of discussion which separated, ideologically, them from their group.

Making Choices

During the final step of the change process, nurses dealt with the incongruities they had identified in various ways. Their final steps in adjusting to displacement were influenced by whether these were able to find re-employment. While some accepted recalls or other job offers others chose to disengage from their connections to nursing. Those who remained unemployed told stories about making peace with their new life without nursing. In all three cases, these nurses talked about making choices that they perceived as reasonable in the context of their lives. Still they acknowledged that some decisions and decision making were beyond their individual and collective control as nurses.

These nurses could not envision any significant change in their individual or collective political power or position. Their lived experience of the displacement event was consistent with documentation about the nurses' location in the hospital organization (Levine, 1989; Wotherspoon, 1994) and the social reality of women's lives. When they had the opportunity to take control and make choices, they did. They chose to do so by accepting work that was offered to them whether it was returning to their displacing employer or part-time work in other settings. As one nurse said, "A job became available and I was not about to let that opportunity go. So, I basically accepted it. It was not a position that I would have wanted."

Sometimes these nurses had to make choices from a list of "seriously flawed alternatives" (Duffy, Mandell & Pupo as cited in Wilson, 1991, p. 35). Several nurses had to choose between holding out for their contractual rights to work (and going without work) or accepting work (any work) that was offered. When income was desirable and the chances of successfully fighting the system were minimal, standing on principle seemed like a less reasonable option. The previously cited example about one nurse's decision regarding bumping also illustrated this point. Her options were limited to bumping another nurse into unemployment or accepting the layoff herself and going on the recall list. In retelling this story to herself and others, her choice was made understandable as an act of political resistance (Gilligan, 1993). In weighing the outcomes, she judged her decision not to bump as taking the higher moral path and resisting institutional practices. Still, there was no right or good choice. In either case someone was going to be hurt.

When some of the participants were recalled to work by their previous employer, they were returning to an institution and a system that had and would continue to oppress

and marginalize them (Duffy & Pupo, 1992). Some accepted the part-time work knowing that it was insecure and probably temporary. The act of choosing was an act of taking control. These nurses conceived of returning to work as a strategy for putting their unemployment behind them, and moving on with their lives. By adopting this new perspective they set new goals. As one RN said, "I really feel that a lot of these things happen for the better. We may not know what the reasons are." Choosing to return to work was a reasonable option. As Heilbrun (1988) said, "the woman may write her own life in advance of living it, unconsciously and without recognizing or naming the process" (Heilbrun, 1988, p. 11).

A few who accepted work in the community explained the reasonableness of their choice. They pointed to the moral and health benefits to the client and family of holistic care, self-directed care, home-based care. There were more opportunities in the community than in the hospital where the number of positions was declining. Working in the community was the way of the future in health care delivery (OMOH, 1993; OMOH, 1994b; OMOH, 1994c). In moving outside their preferred setting they reconstrued their displacement as an opportunity to discover other aspects of nursing. As one RN said, being displaced "opened new doors for me." Opportunity was the way they reshaped their decision to develop new skill sets and to accept more responsibility and a heavier workload. As one said, "I'm really happy I was given the opportunity to go to the other place... because I've learned a lot there. There's a lot more responsibility." They were enjoying improved mental and physical health and a more autonomous nursing practice. In their view, this more than compensated for the lower wage. Just as working part-time was better than not working, accepting a lower wage was better than no wage.

In accepting these jobs in the community they were reproducing the devaluation of their skill and knowledge. They were also participating in the privatization of health services which, as Armstrong (1995b) documented, placed an economic and psychological burden on other women. In order to return to the work they loved to do, they were turning away from a system that was abusing another category of nurses. An RPN who replaced an RN in the hospital setting had less authority and a lower wage, yet she was expected to produce similar patient care outcomes.

In talking about making choices, these nurses echoed the published words of other displaced nurses (Cavanaugh, 1994; Dahlstrom, 1994) who recommended that nurses assume personal responsibility for turning adversity into an opportunity. Like Cavanaugh (1994), these nurses suggested that being laid off was a catalyst for achieving a new perspective, setting new priorities and forcing deliberate choices. As one RN said of her new career direction, "I know I never would have gone that route otherwise." Reshaping life's defeats into opportunities was one of the few stories that have been available to women in our society (Heilbrun, 1988). Reflecting positively on the event or on the process of recovering from the event allowed them to think positively about their future. The way in which these nurses imagined or construed their future shaped their responses in the present and thereby reproduced their past (Gaskell, 1992).

While it may be argued that their choices to return to work reproduced their subordinate position in the health care hierarchy, these nurses did not see themselves as powerless victims of the system. Although they did not think of themselves as powerless they accepted that their experience made them feel powerless. Their displacement experience was a result of how others valued them and not how they valued or imagined

themselves to be.

What responses were available to nurses who were displaced given this relative lack of power within the health care bureaucracy? Institutions like hospitals reflected and recreated women's and nurses' subordination (Levine, 1989). Women were rewarded for conforming and sanctioned for deviating from socially prescribed behaviours. Gradually their faith in the system had eroded. Being displaced had taught them that they would either be ignored or penalized for protesting. They had witnessed the ineffectiveness of their collective political voice. They retold stories about other nurses who were outspoken or who resisted reform initiatives and who were dealt with harshly. They knew society's penalty for stepping outside the bounds of social constraint. As in Hawthorne's The Scarlet Letter, when a woman's script took her outside the bounds of society's restraints, she met with social ostracism (as cited in Heilbrun, 1988). Opportunities for resistance were not perceived to exist or to be available to them. As Heilbrun said, their stories did not include "any narrative that could take the women past their moment of revelation and support their bid for freedom from the assigned script" (p.42). If they wanted to work again in nursing, they could not afford to be unpopular. Without collegial, family or social support, taking a risky path was not a reasonable option. Most chose not to waste energy opposing these social constraints and risk excluding themselves from those options that were available to them.

Berger's metaphor was helpful in discussing the tension between those structural elements in the outermost circles over which these nurses felt they had little or no direct control and those elements in the inner circles over which they felt they had some direct control. In all cases they considered that by making choices they were controlling their

own responses to social constraints. If an RN were to accept work in nursing, these were the conditions under which she must work. In the inner circles of control they were constrained by their desire to be re-employed in nursing. These nurses sought work in their own field because they believed in the intrinsic value of their work and their contribution to the health care delivery. They were constrained by their relatedness to their work and their beliefs about the value of their work. They believed there were patients who needed and deserved the quality care that they were qualified and competent to provide. These were the factors over which they had believed they had control. These nurses were also constrained by forces in the outer circles over which they believed they had no control such as the reduced job market in hospitals, competition for jobs, the economic recession.

Another way in which some nurses in this study adjusted to displacement was to disengage themselves from connections with nurses and nursing. Like the first group, these women shared their stories of grief and anger, their successes and hopes for the future. Also, like the first group, these nurses did not find themselves inadequate or wanting because they had been displaced. Distinguishing them from the other participants was the way they resisted giving up their anger. In contrast to the first group, they had begun to explore issues of inequality and gender that inhibited their personal and collective potential as nurses and as women.

Disengaging from their connections with nursing meant separating themselves from other nurses and the issues that marginalized them. During the conversations these nurses made attempts to understand their political location as nurses in terms of gender. In the opinion of one participant, nurses were powerless because women were "fickle."

Their stories pointed to perceived innate or biological deficits to explain the powerlessness of nurses rather than looking at systemic factors that supported gender arrangement in hospitals. By dissociating themselves from others they perceived as powerless and ineffective, they reproduced their collective powerlessness.

How did these three women place themselves outside the restraints imposed by hospital bureaucracies? They disengaged themselves from the connections that had once linked them with their work. Describing nursing, one participant said, "It's not the end all and be all. And there's more to life than work." One element that distinguished these nurses from the others was the way they related job displacement to other instances in their careers when they had faced contradictions between their beliefs and their lived experience in nursing. When they found that raising a voice of anger individually or with their unions was ineffective in bringing about change, they rewrote their relationship to nursing. They severed or devalued some or all connections with nursing that they had once valued. One said that while she still enjoyed the labour itself and her relatedness to her patients, she described going to work to "create my own little world" in which she cared for her critically ill patient, and then going home. While two nurses were detaching themselves emotionally, another one was severing her all ties with the profession. That nurse recalled her experiences during the process of organizational restructuring which had limited her control over her work, and she had felt increasingly disconnected from her clients. Being displaced gave her the time and opportunity to retrain for a new occupation outside nursing where she expected to enjoy more autonomy in her relationships with her clients. She was planning to leave nursing within the next year.

In holding onto their voice of anger they distinguished themselves from other

members of the research group. Public admission and declaration of anger have been considered unwomanly and unacceptable (Heilbrun, 1988). These women were, at times, challenged in subtle ways by other group members to get past their anger and move on. Unresolved anger was considered to be self-destructive. For the women in this second group, unresolved anger was not a weapon they turned on themselves. Anger was the fuel that propelled their search for answers to the contradictions they had identified. Unfortunately, it was difficult for these women to articulate and examine these issues as they lacked the support to question and the language to name those issues confronting them. Heilbrun (1988) described women's difficulty in finding and using appropriate language to make social comments because of the structural constraints against recognizing anger in oneself, discussing issues of power and control over one's life. One nurse expressed her difficulty in conveying how she made meaning of her displacement saying, "We could talk for days and days on the subject and still not get to the bottom of the whole thing as to what you're feeling."

Some nurses were in the process of making peace. Distinguishing this response from the other responses was that these nurses had not found re-employment. The strongest message in their stories was the search for peace and balance in their lives. As one said, "I always wonder what is happening. What is going to happen to me next year? What is going to happen to me next week?"

Meeting with other displaced nurses validated the grief and anger they had experienced. In sharing their stories with others who had found work they again had to face their own joblessness. They had few stories to tell about their successes and future. Neither was optimistic they would be re-employed either in a nursing or non-nursing job.

Reflecting on the reason for her tears, one nurse said, "I think, maybe because I'm feeling things again, those things that I thought I'd dealt with. But as much as you deal with them, I think that you're still vulnerable."

While the other nurses had resolved many of the issues they confronted after their displacement, the nurses in this group came into the study seeking closure and a way to move past their psychological pain. Discussing their losses made them revisit their sadness and they struggled to put the issues aside. As one said, "I'm at peace, right now, until I talk about it."

One way in which this group was attempting to bring closure was to immerse themselves in those activities that were consistent with the ideologies of motherhood, domesticity and caring. Present in their stories were activities that tend to be associated with women and women's work. They located themselves in their families and volunteer organizations as caregivers. They reflected on their family commitments and whether they had over-invested in work. They focused on restoring balance in their home life.

In reviewing the old genre of female autobiographies, Heilbrun (1988) noted idealized and romanticized versions of women's lives. Characteristically, women did not admit to ambition, or a desire for power or control over their own lives. Achievements, if discussed at all, were attributed to chance, destiny or the efforts and generosity of others. It was in this same way that these nurses reflected on their displacement. As one said, "Life throws you curves." Heilbrun (1988) also noted that female autobiographers, intentionally or unintentionally, denied or concealed their anger, presenting instead exemplary versions of their lives. Commenting on Sarton's autobiography, Heilbrun (1988, p. 12) said she tended to "find beauty even in pain and to transform rage into

spiritual acceptance." In similar ways, these women attempted to conceal their pain. As one said, "You know it's a very silly thing to try and analyze it now because in the situation you do what has to be done. And to reflect back, it's a waste of my time really. That's the way it was and that's what I did... . So no, I would say, I'm not looking back with regrets."

Summary of Findings

How RNs described and made meaning of their displacement experience provided insights into how and why they responded as they did. They, like members of other socially oppressed groups, responded within the context of the narratives available to them. Being a nurse was important work and important to how they defined themselves. Being displaced was, therefore, a distressing and painful event. Initially they experienced grief and sadness, self-blame and doubt. They grieved the loss of their image of self as caregiver. They grieved the disruption of valued connections to work, their clients, their colleagues and their employer.

As the period of unemployment increased they began to express their anger and to question the contradictions between their previously held beliefs and their lived reality. While these nurses supported the need for reform and the vision for a new system of health care delivery, they were angry about the way the process evolved.

These nurses had believed in meritocracy. They valued their education, knowledge, skill and experience. Job displacement, in the view of several felt like a penalty for accepting the pay equity increase and becoming a more expensive resource. Still, they invested considerable energy in efforts to find re-employment and to retrain.

They had believed they were professionals and team players. Being displaced made them feel unvalued by hospital management. From their stories emerged questions about who was valued, what was valued and how value was defined. Although they spoke about how patients and families valued their competence they questioned the lack of public outcry in response to widespread staffing cuts. While they valued patient care, the system seemed more interested in the bottom line.

These nurses had believed in fairness and the democratic process. In telling their stories, they questioned who had the power, and who did not and why. In the same way they felt that nurses had little control over their day-to-day practice, they also felt that they had little control over the process or outcome of reform. Those with the organizational power could dictate and control the restructuring process. It was their experience that health care dollars were being allocated to upgrading technology and renovating the physical plant at the same time management was cutting staff and services. They found that rules were unfairly applied and served the interests of the rule makers and enforcers. They blamed management and the provincial government for cost overruns and poor management practices yet management inefficiencies were ignored. Instead, they found that nurses and patients shouldered the greatest burden of cost-cutting initiatives. They expressed concern about the quality of patient care that resulted from the intensification and techno-focus of nursing labour, and the shifting of elements of their labour to other workers.

These nurses had believed in the power of a strong united political voice and the strength of their local and provincial union. They found their union and union leaders had been ineffective in representing their interests during the restructuring process and in

protecting their jobs and the nature and utilization of their labour. Their stories revealed they felt abandoned by their unions, the nursing profession and other nurses. They had engaged in individual acts of resistance only to have their protests ignored, trivialized or treated with indifference by the government, the public, the media, their management, their former colleagues and sometimes even by their friends and family. Only other displaced nurses seemed able to understand their experience in the ways they understood it.

All these questions constituted serious challenges to their ways of understanding the world. Finding re-employment, even part-time work was a watershed in speeding adjustment through the post-displacement process. Being unemployed had been a difficult condition for these women who enjoyed their work and being re-employed reduced some of the chaos in their lives. While they had been unable to control the events leading up to their displacement, they believed they could control their responses to it. They made their choices from the short list available to them. Several returned to the system that had marginalized them and reproduced their collective oppression. A few disengaged from their connections to nursing and retained their voice of anger. A couple who were unable to find re-employment struggled to find peace and balance in their lives without nursing.

Nursing was a source of professional satisfaction and a source of oppression. These women's stories highlighted the inequalities in power and status within the hospital bureaucracy and the power of structural constraints to limit women's work, potential and choices. A nurse's adjustment to displacement was guided by her preparedness to make difficult choices from among those limited options available to her. The list of choices was limited by political, social and economic factors and the gender arrangements that were integral to all these discourses.

CHAPTER FIVE: SUMMARY, CONCLUSIONS AND IMPLICATIONS

The purpose of this research was to identify and explore the various responses of Registered Nurses to displacement from full-time employment as bedside nurses in general hospitals in southern Ontario. In this final chapter, I summarize the work presented in the preceding chapters and review the research questions. Next, I offer some conclusions from the analysis of the data that were informed by the related literature. Finally, I discuss the theoretical and practical implications of this study.

Summary

This study grew from my experience with organizational downsizing and job displacement, the impact of those events on my professional identity and nursing labour, and my decision to disengage from nursing. I wanted to better understand how structural constraints and human agency guided nurses' meaning making and responses to job displacement. Secondly, I wanted to explore how it was that nurses, the largest occupational group in health care, seemed relatively powerless to save their jobs or protect against the erosion of their labour. There were two assumptions on which this study was predicated. I assumed that the nursing profession and health care system were historically constructed entities. I also assumed that gender arrangements in the health care system and in society were integral to understanding how and why reform unfolded as it did, and how and why displaced nurses responded as they did.

A review of related literature in chapter two examined health care reform and its impact on nurses and nursing labour. Much of the literature, critical of health care reform

and institutional restructuring, emphasized the interplay among the recent economic changes, the role of the state, institutional discourse and practices, and social reproduction within the public and private spheres. The literature describing the impact of reform on nursing and nursing labour also focused on structural constraints, specifically social patriarchy, ideological conflicts, government legislation, administrative policies, nursing education and the professionalization of nursing. While there was a paucity of academic literature describing the experience of job displacement from the perspective of the Registered Nurse, a few displaced nurses have published their stories in nursing journals. These accounts, in contrast to the academic literature, stressed human agency as a way of making meaning of and responding to job displacement. Specifically, these nurses' stories discussed the importance of accepting the reality and inevitability of restructuring and layoffs, and making positive career choices that promoted labour and economic adjustment.

In chapter three, the process of defining the research methodology was described. This study incorporated techniques consistent with principles of naturalistic inquiry and the narrative tradition. A purposive sample was drawn from the Health Sector Training and Adjustment Program database. Using an emergent three-step design, data collection in each step was informed by the data analysis in each of the preceding steps. Data were collected using a questionnaire, and through individual and group interviews.

The demographic data about the participants presented in chapter three were enhanced in chapter four with a discussion of the nurses' narratives. The ten nurses in this study were among the hundreds across the province who were displaced between October 1991 and October 1995 as a result of organizational downsizing and other health care

reform initiatives. Their stories revealed that job displacement was a traumatic life event that disrupted their connections to their work and their ways of understanding the world. In the next section, conclusions from the analysis of the data are offered.

Conclusions

The Process of Labour Adjustment

The first research question asked about the various responses to displacement expressed by Registered Nurses who lost full-time employment in a staff position in a general hospital because of health care reform. These data revealed diverse responses among the ten participants. Also evident was a three-step process used by nurses to reconstrue their social reality and adjust to displacement. The process of labour adjustment involved moving from initial feelings of grief and self-blame, through a period of anger and questioning, on to a point where they were making personal and career choices.

Several potential sources of support were available to these displaced nurses during the process of adjustment: HSTAP, professional nursing associations, nursing management, local union and union representatives, other health care professionals and nursing colleagues, other displaced nurses, friends and family. The women studied found that other displaced nurses provided the most real support in that only they seemed to understand this particular experience of job displacement. This may explain why participating in the project made these nurses feel as if someone really understood and cared about what had happened to them.

Articulating the journey toward labour adjustment was significant to the

participants. These Registered Nurses who had felt isolated, unsupported or confused by the experience of job displacement also found that sharing their stories was validating. Many expressed interest in and support for the goals of the study. The narrative tradition allowed these nurses to be actively involved in "the construction of data about their lives" (Graham as cited in Reinharz, 1992, p. 18). These nurses, like the military wives in Harrison and Laliberté's (1994) study, were grateful for the opportunity to tell their story and be heard. Hearing other nurses' stories was also validating for me emotionally and intellectually as these findings confirmed my displacement experience and helped me clarify some of the dynamics of my decision to disengage from nursing.

For me, job displacement was a turning point in my career. Being displaced caused me to identify and analyze some assumptions which shaped my practice as a nurse and an educator in health care. Engaging in this reflective activity helped me identify some moveable obstacles in my personal and political worlds, and plot a new occupational course. Thus job displacement was for me a critical incident as defined by Brookfield (1990). That is to say, a critical incident is a significant life event which causes the learner (nurse) to explore her assumptive world. I had expected to find displaced nurses in this study describing their job displacement in similar ways. They did not.

While a significant and painful life event for the nurses studied, job displacement, in and of itself, did not prompt these displaced nurses to see their own situation in a broader context. They were confounded and distressed by the discrepancies between their beliefs and their new reality following job displacement. They were angry that they were targeted for displacement. They directed their anger, in large part, at hospital management whom they saw as directly responsible for their job loss. They concluded, as

have Armstrong (1995b), Armstrong and Armstrong (1994b) and Glazer (1993) that government reform initiatives that targeted hospitals impacted heavily on a work force comprised predominantly of women. Several believed, as Campbell (1987) noted, that historically women and nurses have had to absorb a disproportionately heavy burden of cost containment. Still, why this was so was not clear to the women in this study.

One way to approach that clarity was for these women to make explicit their assumptions about nurses, nursing and their relationship to the health care system. This was not something they did. They seemed to view their circumstance as a social "reality" rather than a social construction. While they questioned the process and the outcomes of their displacement and health care reform, they did not scrutinize the accuracy or validity of the political assumptions on which those processes were based.

One way to interpret this finding is to speculate that these nurses have, in the past, questioned assumptions and found the experience "psychologically explosive" (Brookfield, 1990, p. 178). Engaging in such a provocative exercise for the "purpose of research" may have entailed more risk than benefit for these participants. Alternatively, and more likely, is to suggest these participants did not have the tools to identify and explore their assumptions. A different methodology centred around reflective activities may have facilitated an exploration of their assumptions about nurses and health care, thus, offering a different base for contextualizing their job displacement.

Finding re-employment was a pivotal event for these nurses in the final step toward labour adjustment. Leventman (1981) reported similar findings among other displaced professionals. Finding re-employment was also an event after which time these nurses' differentiated themselves from each other by their choices. These choices were three

different paths toward labour adjustment. The individuals in each of these three groupings surveyed their options, and exercised power and control within the limits available to them.

Where re-employment was an option, the women who took the first path resumed their relationship to nursing holding fragile hopes for work and their future. From their location, the nurses in this group could not see any better options. While they wished the process and the outcome of reform had been different, they accepted their displacement was part of the inevitability of downsizing and health care reform. They had not forgotten their anger nor had they forgiven the system for the treatment they had received. They found their access to effective political resistance was limited within the system and even more limited outside the system. Still, they believed they could better use the knowledge and skills they valued by returning to work. Not working offered no advantages. In returning to a system and a relationship that limited their personal and professional power these nurses were reproducing their own servitude. Options for interrupting this cycle of servitude were not visible to them as participants in the health care system or from the support systems potentially available to them.

A few displaced nurses for whom re-employment was an option, were not prepared to return to their prior relationships in health care and reproduce the cycle. The women in this second group refused to be co-opted, and disengaged either psychologically or occupationally from nursing. The single element which distinguished these women from those in the first group was their discussion of other occasions when they, as nurses, had felt abused by hospitals, their managers or the health care system. Job displacement added fuel to the fire of their discontent with the system. Being displaced was viewed as a

door of opportunity through which they could walk away from nursing. While none of these nurses characterized their choices as political activism, they had found a way of interrupting the cycle for themselves.

The nurses in this third group, for whom re-employment in nursing was not an option, talked about searching for balance. There appear to be similarities between the experiences of the unemployed nurses in this study and women who choose to work part-time. Duffy and Pupo (1992) found women who decided to work part-time used the concept of balance to interpret their choice. They argued that the search for balance was gender specific, saying:

> Balance is the outcome of negotiation through the constraints of limited options, structural barriers and the emotional pushes and pulls of family life. Achieving balance represents resistance and oppression, conflict and constraint, and the dialectics of women carving out their own niches. (p. 108)

Displaced nurses and women working part-time were struggling to make meaning of their lives and the limited choices available to them. Both were trying to envision a future wherein their personal and professional needs were satisfied. Their working lives were constrained by political and social forces beyond their control and the search for balance was a strategy for dealing realistically with this dilemma.

While the nurses in all three groups exercised some power and control in their situation, structural forces limited the choices reasonably available to her. Gaskell's (1992) study of vocational choices among high school girls also explored the tension between structure and human agency. In Gaskell's study, as well as in this one, the participants were caught in a cycle which they were constrained to reproduce. These

displaced nurses, like the high school girls, recognized the inequity in the system but they lacked the political power to change their circumstance. These nurses wanted a different relationship to their clients, their work, their employers and the system just as the girls wanted to explore other personal and career choices. In both cases, historical, sociopolitical and ideological forces constrained the range of choices available to them. In both cases, their choices returned them to a system and a political agenda they had not participated in constructing but to which they were subject, and which did not seem to serve them well. Other choices carried heavy risks with little promise of gain. Both the high school girls in Gaskell's study and the displaced nurses in this study made the best choices they could in dealing realistically with their situation. While it might be said that nurses' choices reproduced the cycle of servitude, it is the lack of viable options for interrupting that cycle that must be more carefully examined.

In light of these findings about nurses' responses to job displacement, I conclude that both structural analysis and theories of human agency are needed to explore and document this area of women's experience. Questions about the impact of job displacement on professional identity seem to require a psychological lens to view the nurse as the subject (I, as nurse), as meaning maker and decision maker. Questions about the impact of job displacement on the way nurses understand changes in nursing labour seem to require a sociological lens to view the nurse as the object of action (she, as caregiver and displaced nurse).

Job Displacement and Professional Identity

Kelly's (1963) personal construct theory offered a framework for interpreting the

second research question. This question asked how job displacement impacted on the way Registered Nurses understood, made meaning of, or constructed their professional identity. While Kelly's personal construct theory was intended for use in the teaching and practice of clinical psychology, it has been used by researchers as a framework for understanding personality development outside the psychotherapeutic context. Bond (1993) used the theory to explore concepts of the professional self among teachers, and he cited the use of Kelly by Neimeyer (1990) who examined vocational development and by Oberg (1987) who studied teacher professional development. Holman (1993) used personal construct theory to explore concepts of the professional self among nurses, and she cited the work of Morrison (1989; 1991) and Mazhindu (1992) who also applied the theory to the development of self-perceptions among nurses. In these studies, a number of variables were found to contribute to the construction of a professional identity. It was, given these precedents, that personal construct theory is used in this study as one way of interpreting nurses' responses to job displacement as it impacted on their professional identity.

According to Kelly (1963), an individual's responses are related to the way she anticipates events. Because every individual has a different set of life experiences, she creates a unique set of rules or constructs for understanding her world and predicting events. The individuality corollary holds that how an individual defines herself is based on a subjective interpretation of events and a personal system of constructs. Applying that corollary to this study, how each woman defined herself as a nurse was based on her interpretation of her professional experiences with her clients, her employer and her work. How she responded to job displacement was related to the way she had come to predict

events in her professional life. These displaced nurses, for example, related strongly to their patients whom they perceived as sharing with them the burden of cost-containment strategies.

According to Kelly's (1963) commonality corollary, individuals may share ways of anticipating events and, hence, share similar characteristics. Applied in this case, these women as a group seemed to have similar expectations about being a nurse. Having a job seemed to be an important device for construing the professional self. Nurses' educational and work experiences influenced their perceptions of themselves as nurses. To the extent that these nurses shared a similar culture in the hospital setting, they shared similar ways of construing their relationships to their clients, their employers and their work and, therefore, their professional identity.

The displacement experience was a significant event which disrupted nurses' ways of understanding their reality and viewing themselves as nurses. Their existing constructs no longer helped them to make sense of their world or to predict their professional future. Care, knowledge and technical skill had been promoted by educational curricula, professional associations and the unions as valued characteristics of the ideal nurse. By incorporating these elements into their practice, they had expected that they, as nurses, would be valued. Being displaced disrupted that construction of their professional identity and their ability to anticipate how they would be valued and treated.

Nurses' narratives indicated a significant personal investment in, and dependence upon, their construction of their professional self and their relationship to the health care system. Kelly (1963) suggested that adopting a more comprehensive or precise construct is a formidable task. Since the longevity of a construct is determined by its usefulness as

an anticipatory tool, a construct will be used or revised depending on how well it helps the individual predict and react to events. I concluded that one external influence, re-employment, and one internal influence, prior experience with professional dissonance, seemed to influence whether or not displaced nurses retained or reconstrued their existing construct system.

Re-employment seemed to reduce anxiety and restore predictability in the lives of the women in the first group. Prior to their displacement, these nurses' established constructs had been useful in helping them predict and react to the day-to-day reality of their work. Their constructs continued to be useful anticipatory tools after being re-employed. Returning to work as a nurse affirmed their construction of their professional self and reduced the need to revise their existing construct system. As their constructs had proven to be useful, they were retained, and incongruities were accepted and set aside. Consistent with Kelly's (1963) organization corollary, these women found ways of anticipating events that transcended contradictions. They had organized their construction of events in such a way as to preserve self and job. For example, they characterized their job displacement as an unpleasant but necessary cost-saving strategy and their new jobs as opportunities they might otherwise have missed.

For the displaced nurses in the second group, their established constructs had become less useful anticipatory tools over time. These women recalled prior events which had generated conflict. According to Kelly (1963), dissonance makes existing constructs more permeable and more open to reorganization. Being displaced unearthed the old contradictions. Unlike the experience of the nurses in the first group, re-employment did not reduce their anxiety or restore predictability to their lives. Re-employment amplified

the need to adopt a more precise construct system. The narratives of the women in this second group indicated they were in transition. These were the nurses who were disengaging emotionally or occupationally from nursing. Disengagement from nursing was part of the process of reconstruing the professional self. Their anger and emotional tension were part of that energy devoted to the revision process.

Reconstruing the self was especially difficult for the nurses in the third group who were unable to find re-employment. The chaotic nature of their daily lives was reflected in their tearful stories and their search for peace. They spoke about the difficulty of bringing closure to their displacement experience because working had been an important device for construing their professional self. Being unemployed was a continuous source of anxiety and unpredictability in their lives. They looked for ways of reconstruing themselves and their actions as meaningful and valuable. Again, the organization corollary (Kelly, 1963) is useful in interpreting changes in their identity. These women resolved some of the conflict by a hierarchical reordering of other constructs of self. Identities such as wife, mother, grandmother, violinist, volunteer or community activist became more valued. Reordering these ordinal relationships preserved the construct of self as nurse which had been so important for so many years. Reordering the relationships also resolved their need for self-consistency and anticipatory consistency. The process of adopting a more precise construct system is exhausting and may account for part of their distress. The process of reconstruing self also takes time, of which they had plenty, and considerable energy and support, which were more limited resources for these women.

Job Displacement and Nursing Labour

The third research question asked how the experience of job displacement influenced the way Registered Nurses understood changes in the nature and utilization of their nursing labour. Job displacement was a critical event which caused nurses to regard the inequities in the health care system and the devaluation of their labour.

The impact of job displacement on the participants in this study was significant. Grayson (1993) measured economic adjustment by current employment status, degree of continuity of working hours, and ability to maintain pre-layoff wages and skill utilization. Most experienced long periods of unemployment and underemployment. For most, their work required more skill and training for which they earned a lower wage than they did prior to their displacement. Based on the findings, the nurses in this study were not adjusting economically to job displacement. Although the methodology used in this study precludes making any generalizations beyond the study group, similar findings of poor economic adjustment were reported by Grayson, and Cairns et al. (1994). These findings also support the shift to part-time labour which has been documented by Duffy and Pupo (1992) and Hiscott (1994). Similarly, these nurses' stories also support the trend toward "deskilling" documented by Duffy and Pupo (1992) and of work transfer discussed by Glazer (1993) and Armstrong (1995b).

These nurses' narratives identified the many factors that impacted on their ability to adjust to job displacement: the shift toward the practices of business, the shift toward part-time, lower paid and insecure positions for RNs, limited job opportunities in the hospital setting and the community, their own and HSTAP's limited vision of real employment opportunities in the health care sector, continuous changes in health care, continued

economic uncertainty, their lack of experience and skill with job search techniques, limited or inappropriate retraining options, and nurses' lack of political clout. When discussing these factors, the nurses in this study emphasized their power as individuals to overcome these obstacles to labour adjustment. They did not question why these obstacles existed or why the changes were occurring in this way. They did not question the assumptions underlying health care reform. They were not alone.

The nurses in this study were enmeshed in a system which accepted that Canadians were overspending on health care and that cost cutting and organizational restructuring were needed to preserve medicare. In her review of the American literature on health care reform, Glazer (1993) found social scientists accepted unreflectively assumptions driving health care and the need to embrace the ideology of business. The inevitability of restructuring and layoffs was the starting point for discussion in the work of Canadian nursing researchers (Baumann et al., 1995; Cameron et al., 1994) and in my conversation with union leaders (S. O'Neill, personal communication, July 5, 1995). It is not surprising that these nurses, too, embraced the need to control costs.

Because these women accepted the assumptions underlying the need for reform, they accepted as necessary those cost-saving strategies that altered the nature of their labour. When they began to unearth contradictions between the proposed and the actual outcomes of reform, they focused, not on the assumptive base, but on the process of change that was visible to them. For example, when the management claimed job displacement was necessary to reduce spending, they questioned the health care dollars being allocated to renovations, and to diagnostic and other medical technologies.

Their knowledge, skills and caring were devalued. Registered Practical Nurses

who have a different educational history and skill set were replacing Registered Nurses. While the College of Nurses (1990), whose mandate it is to protect the public, differentiated between the two categories of nurses, government and hospital administration treated the two categories of nurses as interchangeable units of labour. The outcome of replacing RNs with RPNs was three-fold. The RPNs provided a cheaper form of nursing labour. The RNs were relegated to lower paid, insecure, temporary or part-time positions. Patients did not receive the same quality care despite government promises that reform would result in improvements in care and services.

Nurses' narratives reflected the discordance between the values which informed nurses' practice, that is knowledge, skill and care, and those values which informed the use of nurses' labour by others, that is the principles and practices of business. One way of understanding the contradiction was to consider how the term care was used by nurses, and by administrators and government. This term had different operational and practical implications for both groups. The ideology of care has been central to how nurses defined themselves and their labour (College of Nurses, 1990; Yyelland, 1995). For bedside nurses, care has denoted sensitivity, warmth and a manner of being in relation to clients and others. Nursing leaders and researchers supported the dualistic (emotional and technical) nature of nursing labour in the push to professionalism and the appropriation of a unique body of nursing knowledge. Historically, religious imperatives, the ideologies of motherhood and femininity, and the social reproduction between the public and private spheres have reconstrued caring to mean an obligation and duty to care (Achterberg, 1990; Coburn, 1987; Colliere, 1986). The dualistic construction of care became part of the organizational structures and processes through administrative (Yyelland, 1994) and

government policies (Angus, 1995; Yyelland, 1995). Both meanings of care have structured nurses' work and constrained nurses' social and political location in hospitals.

Both meanings of care were evident in the accounts of displaced nurses. Both meanings were perceived by nurses as part of the way things are and ought to be. Displaced nurses agreed that in an ideal world, the role of the bedside nurse was to provide competent and skilled health-related services in a caring manner (College of Nurses, 1990). It was nurses' experience that organizational demands required that technical labour had precedence over emotional labour (Campbell, 1987). Regular job performance reviews rewarded technical skill and proficiency (Wotherspoon, 1994). Organizational restructuring had relegated non-technical or caring aspects of care to the status of "little extras" and "luxury." While bureaucratic discourse valued rationality, objectivity, impersonality and business values (Ferguson, 1984; Mills & Simmons, 1995; Yyelland, 1994), displaced nurses who returned to work in hospitals or the community continued to provide caring labour. Nurses benefited psychologically from providing caring labour to their patients. They rendered care for the love of it and because they had incorporated caregiving into their construction of the ideal nurse. The cost to them and their clients was in adding care after their technical labour and paper work was complete, and often times, during unpaid hours. Caregiving has not had a monetary value either in the public or the private sphere. While nurses recognized caregiving had moral and health benefits for both clients and family (Wizowski, 1994), nurses did not expect it to be valued monetarily. Individual nurses considered caring labour to be a private act directed at individual patients. They did not appreciate that these unpaid acts of care contributed to the quality of health care or to the collective well-being of the health care system as Angus

(1995), Glazer (1993) and Gregor (1995) have argued. These narratives reflected nurses made meaning of how one aspect of nurses' paid labour (the essential caring component) had been decommodified.

The dark side of caring has been examined by Tucker (1995) in her study of Employee Assistance Programs in Ontario school boards. She concluded there were contradictions between the intended and actual use of these helping strategies. She found these counselling programs which were designed to help individuals integrate into the workplace actually shaped individual behaviour to conform with bureaucratic goals and practices. While the programs were intended for all members of the board, the services were generally perceived to be for teachers. Implicit in this is that teachers were more needful of help. This stigmatized the individuals who used the services as well as teachers as a group. As teachers are a largely feminine occupation, this suggests the social structure was gender specific.

There are similarities between Tucker's (1995) work and the findings in this study. In both cases, caring and caring strategies were presented as valued and valuable but actually served institutional purposes. In both cases, caring was used by hierarchical organizations as a tool for shaping and devaluing women's work. Finally, the strategies used to constrain women's performance and potential were concealed in apparently benign social discourse and practices. Gender politics accounted for the different operational and practical uses of care in both contexts.

Gender Politics

Discussions of gender politics have been woven throughout the literature critical

of health care reform, and historical and social construction of nursing and nursing labour. As I entered into this project, I had expected to find a similar discussion among nurses displaced from full-time employment. I expected to find them grappling, as I had, with questions about why nurses had not launched a loud, political response to hospital downsizing and the displacement of hundreds of Ontario nurses. To my surprise, gender politics was absent from these women's narratives. Repeatedly when asked to explain why they had been excluded from decision making, they explained that that was the way it was and the way it had always been. When asked to make meaning of the reform process and outcomes, they replied there was no way to make sense of it. To them, it made no sense. Throughout the analysis of the data, I searched for the reasons why this was not a part of their meaning making.

It is my conclusion that these displaced nurses had neither the language nor the tools to examine the forces constraining their action. It has been nurses' experience that hospital bureaucracies were impermeable and static; their processes invisible to scrutiny. This was especially evident in the way these nurses made meaning of the role played by their union during the process. When trying to explain the powerlessness of their union and union leaders they pointed to the individual failure of their representatives whom they claimed were incompetent, unknowledgeable, and ineffective negotiators. That ONA was a union composed largely of women was offered as proof of women's ineptitude in business and as negotiators. The structural constraints of being a predominantly female union dealing with a predominantly male bureaucracy were not discussed.

In general, these displaced nurses were unable to identify those political and economic forces that acted upon them. Only one questioned the power of physicians as

gatekeepers. None explored how funding arrangements maintained the power of physicians in health care. When gender was raised as a possible explanation for targeting nurses it was to point to innate deficiencies of women in general or the failings of individual women to compete with men on their terms or to employ effective business practices. This was especially evident in their review of union activity following job displacement. Collective action was not considered more effective than individual action as a means of bringing about change. When evaluating the ineffectiveness of their unions, they pointed to the individual failure of union leaders citing their ineffectiveness, lack of knowledge, incompetence and inability to seize control. They were unable to see that the sociopolitical forces which marginalized their occupational group may be the same as those that constrained the political effectiveness of their union.

While this methodology facilitated the identification and the description of these data, it did not allow the participants to question in a structured way any of the contractions they exposed. The methodology did not employ any reflective tools that may have facilitated an exploration of their assumptions and beliefs. Their knowledge, language and perspective had been constrained by the structure they were trying to examine. Nurses' educational training and organizational experience have impacted on nurses' ways of seeing the world. At times these nurses seemed to walk all around the issue of gender arrangements. At times it seemed to be implied in their stories. Yet, when invited to expand on these concepts, they seemed unable to move beyond a restatement of the details. Some told another story which seemed to illustrate the same intangible or illusive theme. It was, at times, as if they were searching for a way of conveying a theme which they had not been able to grasp or name. On the one or two instances in the last

group conversations when I named and asked them to comment on the ways that being a woman and a nurse were related to job displacement, the issue was politely side stepped or gently rejected. They returned to discussions about the economic necessity of downsizing.

As Angus (1995) reported, some nursing leaders felt the size and diversity of nursing has been used as an excuse by government to limit consultation and partnerships. While these explanations were offered, response by nursing leaders, unions and academics has not been swift and angry. Yet to accept these excuses as legitimate or reasonable would be ludicrous. In a democracy, where the size of a group has been regarded as a significant determinant of that group's political power, it would follow that nurses, the largest occupational group in the health care system, should have been the government's primary partner. Nurses should have been consulted extensively and extended power, mandate and resources during the reform process at least equal to, if not greater than, the physician group or the hospital association. Clearly this was not the case. Nursing is no more diverse than the medical profession in terms of categories, dimensions or practice settings. The two categories of nurses, RNs and RPNs differ in depth and breadth of knowledge in the same way that physicians have generalists and specialists whose depth and breadth of knowledge differ. Nurses work in diverse practice settings in the same way that physicians do. Nurses, like physicians, have different occupational foci whether that is research, education or practice. So diversity of occupational group is not a legitimate excuse for limiting consultation and partnership. The much more credible explanations for nurses exclusion are the degree of professional autonomy, social and organizational status and power accorded each group on the basis of gender dominant composition of each

group.

Implications and Recommendations

Theoretical Implications

Because there has been little written about the experience of job displacement from the perspective of the nurse who was displaced, the strength of this research methodology was in identifying and describing nurses' responses. While I had made some informal observations based on my experience with job displacement, responses had not been studied. Based on the insights into job displacement that were revealed in these nurses' narratives, I now offer the following recommendations for further study.

These displaced nurses did not appear to have adjusted economically to job displacement. While several held one or more part-time positions, all but one would have preferred to return to full-time employment. Of those who were working, most were earning lower wages than they did prior to their displacement. Most reported that they were unable to maintain the same skill utilization and felt their new jobs required more skill or training. These data seemed to support the findings of Grayson (1993) who found that former hospital workers were not adjusting economically to job displacement. Other sources (Duffy & Pupo, 1992, Hiscott, 1994; Leventman, 1981) have suggested that income plays a significant role in defining women's experience in the public and private spheres. An interesting insight revealed in this study was that job displacement for bedside nurses was more strongly related to loss of connectedness to work, clients, and colleagues than to loss of income. Because this methodology did not allow for an in-depth exploration of economic adjustment credible explanations for this finding were not

possible. Further research which provides a comprehensive picture of economic adjustment as understood by displaced nurses may shed more light on this question.

Kelly's (1963) personal construct theory was a useful framework for viewing changes in the way displaced nurses reconstrued their professional identity. This study suggests that construing professional identity is influenced by a nurse's relatedness to her clients, her managers and her colleagues. Developing a descriptive study that uses an adapted repertory grid technique may explore: (1) the ways that job displacement influences the development of the professional self; and (2) the importance of pre- and post-displacement patient-nurse, manager-nurse and nurse-nurse relationships in perceiving self as nurse.

From the selected literature review in this study, it appeared that nursing research accepted rather than challenged the sociopolitical forces driving health care reform. Literature written by nursing academics (Baumann et al., 1995; Cameron et al., 1994) assumed the inevitability of restructuring. Gregor (1995) charged that nursing leaders' acceptance of the rationalization and privatization of nursing care constituted complicity with government initiatives and contributed to the erosion of nursing practice. Do most articles like those written by Cavanaugh (1994), Cohen (1994) and Dahlstrom (1994) encourage nurses to accept the assumptions, process and outcomes of organizational downsizing instead of challenging reform? Would a systematic review indicate that some journals for nurses remain silent on the issue of health care reform? A systematic review of nursing and health literature may clarify the spectrum of literature available to bedside nurses. This review may expose the ways that nursing literature reproduces the structural constraints that control the development of nursing and silence women's voices. Such a

review may indicate whether nurses are being offered the tools and the language to question the assumptions underlying health care reform.

One way to move beyond documenting and interpreting nurses' responses to job displacement would be to politicize future research. Lather (1991) has challenged researchers to explore a "paradigm concerned with both producing emancipatory knowledge and empowering the researched" (p. 70). One way of politicizing the research would be to use self-reflective strategies that enabled participants to critically examine their own knowledge and their own location as women, nurses and displaced workers. Self-reflective strategies described by Lather may allow displaced nurses the time and the tools to investigate the gendered nature of their relationship to the health care system. Using Lather's approach may also provide a means of investigating the utility and limits of self-agency, consciousness raising and reflectivity in bringing about an improvement in nurses' lives.

Another way of politicizing the research would be to use strategies that allowed women to analyze the differences as well as the similarities in their stories. Bales (1996) found that allowing participants to explore differences as well as similarities assisted them in identifying structures and processes that limited their choices and actions, and better prepared them to change their location. While the methodology of this study focused on finding commonalities or similarities in patterns of responses, Bales' approach may offer a strategy for exploring differences in the responses of displaced nurses, for naming conflicts in ideologies, or for questioning care and education as tools of oppression.

Incorporating Lather's (1991) and Bales' (1996) strategies would add a critical component by engaging displaced nurses in discussions about their access to power as

nurses. Politicizing the research might also allow for an exploration of nurses' concept of resistance within institutional and social patriarchy and their choice of tools for responding to displacement.

While this research focused on RNs' responses to hospital reform, future research could look at the other category of nurses, RPNs, who have been heavily impacted by reform initiatives. Such a study might explore the responses of RPNs to organizational restructuring and changes in the nature and utilization of their labour. Unlike RNs, who are members of a union comprised exclusively of nurses, RPNs are members of CUPE, a union comprised of men and women of various occupational groups. Studying Registered Practical Nurses may offer some useful insights into the ways those in this category of nursing express concepts of political resistance and make meaning of their position in the health care system.

Implications for Practice

This study suggested that the term care is problematic for nurses. The ideology of care has shaped nurses' identity and labour, and reinforced the subordinate position of women in health care. Nurses' education has been one vehicle for imposing these ways of understanding care and incorporating these meanings into identity and practice. Nurses' education may also be a vehicle for promoting some theoretical distance by problematizing care. Educational programs might challenge the nurse-to-be to consider what care means, what it has meant, what it could mean, and what should mean. Nurses, who in their early socialization have support in questioning the multiple meanings of care, may be less likely to adopt discourse and practices that reproduce the negative aspects of caring.

This study also suggested that these displaced nurses did not have the tools, the opportunity or the perceptual distance to examine the system in which they were enmeshed. Basic and continuing education for nurses may provide such opportunities and tools for examining the historical, structural and ideological forces that have shaped their occupation and their labour. Learning objectives might include an exploration of current institutional practices, health care reform, and organizational downsizing. Learning strategies which foster critical reflection, like those advocated by Brookfield (1990), Cranton (1992), Hart (1990) and Mezirow (1990), may be well suited to this curriculum. Hart, for example, considered consciousness raising a "tool for transformative learning" (p. 47) and one way to encourage critical reflection.

Consciousness raising assumes the marginality of a social group and offers a way to combine theory and practice for the purpose of sociopolitical liberation. A program for nurses using this educational strategy might begin by acknowledging the similarities and differences between nurses', and other health care professionals' relationships to the health care system. To achieve this end, nurses might use theories of power and oppression to frame their individual experiences with power relationships in health care. This process may empower nurses and their ways of knowing the world, and help them identify those groups who are oppressed (nurses), and those who are privileged (physicians, administrators, government bureaucrats). Their findings would be directed toward planning and supporting practical, personal and social action.

Emancipatory educational experiences may be especially useful to nurses who are actively involved in professional associations and unions. Challenging existing beliefs and assumptions may result in questioning established ways of acting and reacting to the

redistribution of nursing labour. Self-reflective strategies may, for example, offer nurses alternative ways of viewing client self-care, and client autonomy and empowerment that have been increasingly prevalent in Ontario nursing curricula (Campbell, 1987; Wotherspoon, 1994), hospital mission statements (Wizowski, 1994) and reform initiatives (Premier's Council on Health Strategy, 1991; Working Group on Health Services Utilization, 1994).

This study suggests the need to recognize and deal with the diversity of displaced nurses. The displaced nurses in this study were not an homogeneous group, and the pace and direction of their labour adjustment varied. These insights about how social and organizational constructs impact on meaning making, and professional identity may be useful to employer groups and other agencies planning retraining or labour adjustment programs for displaced nurses. Currently, training and adjustment programs are dedicated to helping nurses find re-employment in nursing or to retrain for other kinds of employment. Strategies aimed at promoting labour and economic adjustment must consider the varied responses to job displacement documented in this study.

One such strategy may address the need for building support networks dedicated to displaced nurses. The focus of these networks would be unlike other support or self-help groups for displaced workers. The conceptual basis for most support groups for the unemployed has emphasized support and counselling (Davies, 1996). Davies documented that social support mitigated some of the effects of unemployment. She advocated a newer trend in self-help groups for displaced workers. Davies and Human Resources Development Canada (1994) have focused on promoting individual responsibility and effort, and developing work and job search skills. In both venues, however, problem

resolution was returned to the individual and directed attention away from the social, economic and political issues that caused unemployment.

The kind of social network I am suggesting builds on the identified need for social support and planning action. A network dedicated to bedside nurses would respect their specific location in the health care hierarchy. The distinguishing feature would be a focus on the collective experience as a way to challenge assumptions and frameworks for construing the world and name those issues that constrain personal and occupational potential. In this setting, nurses would have support for making riskier choices that without the support of others would be too time and energy consuming. As Heilbrun (1988) wrote,

> I do not believe that new stories will find their way into texts if they do not begin in oral exchanges among women in groups hearing and talking to one another. As long as women are isolated one from the other, not allowed to offer other women the most personal accounts of their lives, they will not be part of any narrative of their own. Like Penelope awaiting Ulysses, weaving and unweaving, women will be staving off destiny and not inviting or inventing or controlling it. (p. 46)

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Appendix A:

Letter of Approval from Brock University

Standing Subcommittee on Research with Human Participants

Brock University

Research with Human Participants **Extensions 3573/3127, Room B317**

FROM: R. Ogilvie, Chair
Standing Subcommittee on Research with Human Participants

TO: C. Reynolds
Education

FILE: **95-130**

DATE: **December 18, 1995**

The Brock University Standing Subcommittee on Research with Human Participants has reviewed the research proposal:

Impact of Hospital Downsizing on Registered Nurses Displaced from Full Time Employment
Diana L. Gustafson

The Subcommittee finds that, overall, this proposal conforms to the Brock University guidelines set out for ethical research. The researcher may proceed with the work as soon as the following issue is addressed:

1. Add information re how to reach advisor (Brock phone #).

Please submit a letter indicating how you have addressed this concern.

Appendix B:

Covering Letter to Potential Participants from HSTAP

HEALTH SECTOR TRAINING AND ADJUSTMENT PROGRAM

H·S·T·A·P

PROGRAMME DE FORMATION ET D'ADAPTATION DE LA MAIN-D'OEUVRE DU SECTEUR DE LA SANTE

P·R·O·F·A·S·S

January 26, 1996

Dear HSTAP Registrant,

Diana Gustafson, a graduate student at Brock University is conducting a study about the impact of job displacement on Registered Nurses. This research has my support. It has also passed the Brock University Ethics Committee. Information about her research is enclosed.

Your participation in this study is voluntary. Your decision about whether or not to participate will not infringe on your eligibility to access the job registry, funding for training, or any of the other services provided by HSTAP. You may also withdraw from the research at any time, and for any reason without penalty.

To protect the identity of all HSTAP registrants, an HSTAP official assisted during the selection of potential participants. Your file number was randomly selected from the database. The participant code number which appears on the questionnaire has not been associated with your name or file. The envelopes were addressed and posted from the HSTAP office to maintain confidentiality. Only your first name and phone number were released under separate cover to Diana so that she can contact you to discuss your participation in the study.

Please direct any questions about the study to Diana Gustafson, principal researcher at (905) 689-5288 or Dr. Cecilia Reynolds, faculty advisor at Brock University at (905) 688-5550 ext. 3354.

Yours truly,

Sue Colley
Executive Director

Appendix C:

Letter to Potential Participants

Brock University

Faculty of Education
Graduate and Undergraduate Studies

St. Catharines, Ontario
Canada L2S 3A1

Telephone (905) 688 5550 Ext. 3310
Fax (905) 688-0541

[Date]

Dear Colleague,

I would like to invite you to take part in my research study about nurses displaced from full time employment by hospital reform.

Your experiences and insights will be very helpful to me in developing an understanding of what it is like to be displaced from full time work as a bedside nurse. I will be interviewing Registered Nurses who lost their jobs between October 1991 and October 1995 as a result of hospital restructuring or downsizing.

If you agree to take part, the study will involve completing a brief questionnaire and attending three interviews. The first interview with me will last 20-45 minutes. The other two interviews will be with me and four other nurses who have also been displaced. The first group interview will last 60-90 minutes and the second group interview will last 30-45 minutes. All interviews will be conducted in a public building like a library or community college.

Enclosed is a **description of the study** and examples of what I plan to ask during the interviews. Also enclosed is a **brief questionnaire** I would ask you to complete and bring with you to our first interview. Finally, I am enclosing a copy of the **consent form** for you to read and keep for future reference.

If your name is randomly selected, I will be calling you between [dates] to ask if you are willing to participate in this study, and able to attend all three interviews. During that conversation, I can answer your questions and give you more information.

I believe this study is very important. Other displaced nurses and those who may be displaced in the future, can learn from your experiences. **Thank you for giving my research your consideration. I hope you will agree to take part!**

Sincerely,

Diana Gustafson, Principal Researcher
Graduate Studies in Education
[phone number]

Dr. Cecilia Reynolds, Faculty Advisor
Brock University, Faculty of Education
(905) 688-5550 Ext. 3354

Appendix D:

Information Sheet about the Study

Information Sheet about The Study

I am a graduate student in the Brock University Masters of Education program. My learning interests are health care reform and organizational restructuring. I am also a Registered Nurse with many years experience working in hospitals. Like you, I was displaced from full time employment in a hospital as a result of downsizing. For my thesis, I am studying the impact of hospital downsizing on RNs from the perspective of the staff nurse who is displaced.

Although there are many references in the literature to hospital downsizing, none describe it from the displaced nurses' perspective. To understand this viewpoint, I would like you to complete a brief questionnaire and attend three interviews. On the first occasion, I will interview you individually for 20-45 minutes. On the other two occasions, I will interview you as a member of a group of five nurses who have been displaced. The first group interview will last 60-90 minutes and the second group interview will last 30-45 minutes.

All information collected from the questionnaires and during the interviews is confidential. Interviews will be conducted in a public building like a library or community college. The interview location will be as close and convenient as possible for all participants.

Here are examples of what I plan to ask during our interviews.

Think back to the time you were displaced from your job as a bedside nurse. What can you tell me about that event? Can you recall your initial reactions? How have your feelings changed over time? How are you dealing now with being displaced?

Hospital reform and organizational downsizing have affected when, how, and from whom patients receive care. How has the experience of being displaced affected the way you feel about being a nurse; about the work nurses do; about the nursing profession?

What are your plans for the future? How do you plan to achieve your goals? What strategies have been most useful to you or given you the greatest sense of control? What insights would you share with other nurses who were displaced or fear they may be displaced?

Your answers to these questions will help me describe nurses' responses to being displaced from full-time employment as a bedside nurse. In this way, my research can help others who are displaced or who may be displaced.

I hope you will agree to take part!

Diana Gustafson, Principal Researcher
[phone number]

Dr. Cecilia Reynolds, Faculty Advisor
(905) 688-5550 Ext. 3354

Appendix E:

Consent Form for the Study

BROCK UNIVERSITY
DEPARTMENT OF EDUCATION

Consent Form for Study

Title of Study: *Impact of Hospital Downsizing on Registered Nurses Displaced from Full Time Employment*

Name of Participant: _____ *(Please print)*

I understand that this study in which I am agreeing to participate will involve identifying and exploring the responses of Registered Nurses to their displacement from full time hospital employment. Participation includes completing a questionnaire and attending three interviews: one personal and two group interviews. These interviews will be tape recorded. I will have the opportunity to edit a copy of my personal interview transcript prior to sharing it with 1-4 other participants. I will be asked to read an edited copy of the interview transcripts shared by these same 1-4 participants.

I agree to respect the confidences shared by other group members both in the form of transcripts and group discussion. I agree to return all interview transcripts that I am given to read. With the exception of sharing transcripts in the manner described, I understand that only the researchers named will have access to the data. All details that may identify participants or their current or past employers will be removed prior to dissemination or publication. I understand the information obtained from the questionnaires and during the interviews will be used for the specified study only and that it will be shredded or erased at the end of five years.

I understand that participation in this study is voluntary and that I may withdraw from the study at any time and for any reason without penalty. I understand that there is not obligation to answer any question that I consider invasive.

I understand that I will be given a copy of my personal interview transcript. I will be mailed a copy of the thesis abstract after September 1, 1996. I will have access to a copy of the final thesis through Brock University Instructional Resource Centre.

Participant Signature: _____ Date: _____

I have fully explained the purpose and procedures of this study to the above volunteer.

Researcher Signature: _____ Date: _____

Thank you for agreeing to participate! Please keep a copy of this form for future reference. If you have any questions or concerns about your participation in the study, you may contact **Diana Gustafson** at [phone number] or **Dr. Cecilia Reynolds** at (905) 688-5550 ext 3354.

Appendix F:

Participant Questionnaire

Participant Questionnaire

Thank you for agreeing to participate in this study! **Participant Code: 000**

Your answers to these questions will help me in understanding how job displacement has affected you. Please bring this completed questionnaire with you to our first interview.

This questionnaire will take you about 5 minutes to complete. Mark your answers with a ☒. Some questions may ask you to provide a brief explanation. There is space for additional comments on the last page. You do not have to answer any question you consider invasive.

1. **What first name or pseudonym will you use during our interviews?** _____

2. **Gender:** ☐ F ☐ M

3. **Age:** ☐ 20-29 yrs ☐ 30-39 yrs ☐ 40-49 yrs ☐ 50-59 yrs ☐ 60+ yrs

4. **When were you displaced from full time employment?** Month: ___ Year 199_

5. **Have you been displaced from full time employment as a result of hospital downsizing more than once since 1991?**

   ☐ no ☐ yes (please explain)

   _____

   _____

6. **At what kind of general hospital were you working at the time you were displaced?**

   ☐ community hospital ☐ teaching hospital
   ☐ other (please specify) _____

7. **In what county was that general hospital located?**

   ☐ Halton ☐ Norfolk
   ☐ Hamilton-Wentworth ☐ Peel
   ☐ Lincoln ☐ Waterloo
   ☐ other (please specify) _____

8. **What education had you <u>completed before</u> you were displaced?** (check as many as applicable)

- ☐ diploma in nursing
- ☐ bachelor's in nursing
- ☐ bachelor's in other than nursing
- ☐ master's in other than nursing
- ☐ certificate in nursing (please specify) _____
- ☐ diploma in other than nursing (please specify) _____
- ☐ non-credit workshop (please specify) _____
- ☐ other (please specify) _____

9. **What training, if any, have you <u>completed since</u> the time you were displaced?**

(please specify) _____

10. **In what training, if any, are you <u>currently enrolled</u>?**

(please specify) _____

11. **What is your <u>current</u> employment status?**

- ☐ unemployed and ...
  - ☐ looking for work in nursing
  - ☐ looking for work in other than nursing
  - ☐ not looking for work
  - ☐ attending training
- ☐ employed ...
  - ☐ in nursing
  - ☐ in other than nursing & looking for employment in nursing
  - ☐ in other than nursing & not looking for employment in nursing
- ☐ self-employed ...
  - ☐ in nursing
  - ☐ in other than nursing
- ☐ other (please explain) _____

_____

12. **What is your <u>preferred</u> employment status?**

- ❑ permanent full time
- ❑ permanent part-time
- ❑ casual
- ❑ prefer not to work in nursing (please explain) _____
- ❑ temporary full time
- ❑ temporary part time
- ❑ on call

_____

_____

13. **If you are currently employed in nursing, who is your <u>current</u> employer?** (If you are not currently employed in nursing, skip to question #19).

- ❑ general/acute care hospital
- ❑ extended care/chronic care hospital
- ❑ home for the aged/retirement home
- ❑ public/community health centre
- ❑ business/occupational health
- ❑ educational institution
- ❑ other (please specify) _____
- ❑ rehabilitation/convalescent hospital
- ❑ nursing home
- ❑ physician's office/family practice unit
- ❑ home care/visiting care agency
- ❑ employment agency/private duty
- ❑ self-employed in nursing

14. **Do you have more than one employer in nursing?**

- ❑ no
- ❑ yes (please explain)

_____

_____

15. **What is your <u>current</u> employment status in nursing?**

- ❑ permanent full time
- ❑ permanent part-time
- ❑ casual
- ❑ other (please specify) _____
- ❑ temporary full time
- ❑ temporary part time
- ❑ on call

16. **How long did it take you to find your <u>current</u> employment in nursing?**

(please specify) _____

17. **How would you describe your current job in nursing as compared with your job at the time of your displacement?**

- ❑ same employer and... ❑ same job
  - ❑ similar job/different unit
  - ❑ different job requiring more skill and/or training
  - ❑ different job requiring less skill and/or training
- ❑ new employer and... ❑ similar job
  - ❑ different job requiring more skill and/or training
  - ❑ different job requiring less skill and/or training
- ❑ other (please explain) _____

_____

18. **How would you describe your <u>current</u> earnings in nursing?**

- ❑ *less than* you were earning at the time of your displacement
- ❑ *about the same as* you were earning at the time of your displacement
- ❑ *more than* you were earning at the time of your displacement
- ❑ other (please explain) _____

_____

19. **Do you have additional comments that would be helpful in understanding how job displacement has affected you?** (Use another page if necessary).

_____

_____

_____

Thank you for completing this questionnaire!
Please bring it with you to our first interview.

Appendix G:

Format and Questioning Guide for Personal Interview

Format and Questioning Guide for Personal Interview

Prior to the Interview

Participants will have another opportunity to clarify any questions about the purpose or format of interview. They will be asked to read and sign an informed consent form. If the participant chooses to sign the consent form, the personal interview will proceed and the participant questionnaire will be collected. If a participant chooses not to sign the consent form, she will be thanked for her interest in the study, the discussion will be terminated and the questionnaire will not be collected.

Beginning the Interview

The principal researcher will remind the participant that:

- participation is voluntary; she may withdraw from the study at any time and for any reason without penalty
- she may choose not to answer any question she considers invasive
- the interview will be tape recorded;
- all information is confidential
- she may use a pseudonym, if desired.

During the Interview

Think back to the time you were displaced from your job as a bedside nurse. What can you tell me about that event? Where and when did it happen? Can you recall your initial reactions? How did you explain your job displacement to your family; your friends? How have your feelings and responses changed over time? How are you dealing now with being displaced?

Health care reform has resulted in many changes in organizational structure and health care delivery. Hundreds of nurses all over Ontario were displaced. Why do you think nurses in your hospital were displaced? Why do you think you were displaced?

There are a variety of ways that people can respond to displacement. We don't know the various ways nurses are responding to displacement that results from hospital downsizing. How have you responded to being displaced?

The Standards of Nursing Practice say being a Registered Nurse means having a specialized knowledge base, practicing a special set of technical skills, and providing a health-related service in a caring manner. How has the experience of being displaced affected the way you feel about being a nurse? How do you feel about nursing as a profession?

In your work as a bedside nurse, you provided direct patient care. Hospital reform and organizational downsizing have affected when, how, and from whom patients receive care. How has being displaced affected the way you feel about the work that nurses do?

Ending the Interview

The principal researcher will:

- remind the participant that she will have the opportunity to edit a copy of her own interview transcript before sharing it with other participants
- remind the participant that she will receive edited copies of the interview transcripts of other members of her small group; she will be asked to read them in preparation for the group interview
- thank the participant for her participation in the interview.

Appendix H:

Letter Accompanying Unedited Personal Interview Transcript

[Date]

Dear [Name of Participant],

Thank you for participating in the first interview. I appreciated the way you shared your story and your feelings with me. I think that we had a great conversation! I'm really looking forward to meeting with you again.

Enclosed is copy of your interview transcript. Please read it carefully. Think about whether you are prepared to share with other group members:

- a copy of this transcript as it is now appears *or*
- an edited copy of this transcript after some text is deleted and restricted to our eyes only *and/or*
- an edited copy of this transcript after some text is deleted and not included in the study.

Use the enclosed self-addressed, self-stamped envelope to return the transcript to me on or before [date]. Let me know your decision about the transcript. If it is more convenient for you, you may leave a message for me at [phone number]. Also, let me know if the date, time, and location of the first group interview is convenient for you.

I would like to schedule the first group interview on:

[Date]
[Time]
[Location]

Sincerely,

Diana Gustafson
Principal Researcher
[phone number]

Dr. Cecilia Reynolds
Faculty Advisor
(905) 688-5550 Ext. 3354

Appendix I:

Letter Accompanying Edited Personal Interview Transcripts

[Date]

Dear [Name of Participant],

Thank you for taking part in this study! Now, its time to move on to the second step.

Enclosed are the edited transcripts of the interviews with the [number] other members of your small group. Reading these transcripts will acquaint you with [names of other group members], and how they responded to displacement. This will "break the ice", and prepare you to discuss your experiences as a group.

This is what I plan to ask during our first group interview:

You've had the opportunity to read your own interview transcripts. Are there any comments or issues you want to expand or clarify?

You've also had a chance to read the interview transcripts of other members of this group. How did reading their stories make you feel? Which comments stand out in your mind?

You have all shared a common experience - being displaced from full time employment as staff nurses. What do you think accounts for the variety of responses you had?

Hundreds of Registered Nurses like you have been displaced since health care reform began in the early 1990s. How do you make sense of the dramatic changes that are affecting nurses and nursing practice?

These interview transcripts are confidential. Keep them in a safe place and do not share them with anyone. Please bring all copies of the interview transcripts with you when you come to the group interview.

The first group interview is scheduled for **[Date]** at **[Time - Time]** at **[Location]**. If you have any questions, please call me.

Sincerely,

Diana Gustafson, Principal Researcher
Graduate Studies in Education
[phone number]

Dr. Cecilia Reynolds, Faculty Advisor
Brock University, Faculty of Education
(905) 688-5550 Ext. 3354

Appendix J:

Format and Questioning Guide for First Group Interview

Format and Questioning Guide for First Group Interview

Beginning the Interview

The principal researcher will remind the participants:

- that participation is voluntary; they may withdraw from the study at any time and for any reason without penalty
- they may choose not to answer any question they consider invasive
- that the interview will be tape recorded
- that information shared by all participants is confidential
- to use first names only when introducing themselves or referring to others
- they may use a pseudonym.

During the Interview

You had the opportunity to read your own interview transcripts. Are there any comments or issues you want to expand or clarify?

You also had a chance to read the interview transcripts of other members of this group. How did reading their stories make you feel? Are there any comments that stand out in your mind?

You all shared a common experience - being displaced from full time employment as staff nurses. What do you think accounts for the variety of responses in this group?

Hundreds of Registered Nurses like you have been displaced since health care reform began in the early 1990s. How do you make sense of the dramatic changes that are affecting nurses and nursing practice?

Ending the Interview

The principal researcher will:

- remind the participants that they will receive a transcript of this group interview
- ask the participants to read the group transcript prior to the second group interview
- collect all copies of the personal interview transcripts
- thank each group member for her participation in the interview

Appendix K:

Format and Questioning Guide for Second Group Interview

Format and Questioning Guide for Second Group Interview

Beginning the Interview

The principal researcher will remind the participants:

- that participation is voluntary; they may withdraw from the study at any time and for any reason without penalty
- that they may choose not to answer any question they consider invasive
- that the interview will be tape recorded
- that information shared by all participants is confidential
- to use first names only when introducing themselves or referring to others
- they may use a pseudonym.

During the Interview

You had the opportunity to read the transcript from our group interview. Are there any comments or issues you want to expand or clarify?

Over the course of these discussions, we have talked about how job displacement has affected you individually and collectively. How do these conversations help us understand why:

- nurses were targeted for job displacement
- nurses are accepting of the changes that have come with hospital reform
- nurses feel they have no control over their work, or the outcome of hospital reform or organizational restructuring?

What conclusions have you drawn about:

- the value of training and retraining?
- the value that management, the government, and our society places on caring, and the caring aspects of nursing
- changes in who, when, where, and how patients receive health care
- the future of nursing as a profession
- the political agenda driving health care reform?

Ending the Interview

The principal researcher will:

- collect all copies of the group interview transcripts
- thank each group member for her participation in the study
- remind group members that they will receive a copy of the thesis abstract after September 1, 1996
- remind participants they will have access to the thesis through the Brock University Library and Instructional Resource Centre in St. Catharines.

Appendix L:

Letter Accompanying Group Interview Transcript

[Date]

Dear [Name of Participant],

Our last conversation was interesting and productive. I was particularly interested in [specific comment or insight raised by participant]. I've added that to our list of issues to discuss. Our final meeting is scheduled for **[Date]** at **[Time - Time]** at **[Location]**.

Enclosed is a copy of the transcript from our last conversation as a group. Reading this transcript will help you prepare to discuss these issues. **This is what I plan to talk about when we meet next time.**

Over the course of these discussions, we have talked about how job displacement has affected you individually and collectively. How do these conversations help us understand why:

- nurses were targeted for job displacement
- nurses are accepting of the changes that have come with hospital reform
- nurses feel they have no control over their work, or the outcome of hospital reform or organizational restructuring?

What conclusions have you drawn about:

- the value of training and retraining?
- the value that management, the government, and our society places on caring, and the caring aspects of nursing
- changes in who, when, where, and how patients receive health care
- the future of nursing as a profession
- the political agenda driving health care reform?

This interview transcript is confidential. Keep it in a safe place and do not share it with anyone. Please bring it and all other interview transcripts with you when you come to our final group meeting. If you have any questions, please call me. **I appreciate your continued interest in this study!**

Sincerely,

Diana Gustafson, Principal Researcher
Graduate Studies in Education
[phone number]

Dr. Cecilia Reynolds, Faculty Advisor
Faculty of Education, Brock University
(905) 688-5550 Ext. 3354